Maternal and Child Health Services
Title V Block Grant

State Narrative for West Virginia

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are located at the following address:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2010/ While there has been established federal expectation that public forums be held around the Block Grant, West Virginia has found this to be an expensive and inefficient, less than effective means of having topical discussions about the use of Title V resources. To counter this, OMCFH has involved critical stakeholders in all facets of charting a course for the use of multiple funding streams that support maternal, child and family health activities in our State. The use of stakeholder advisories, task forces to study particular population groups and issues, engagement with established non-Title V advisories where we have a seat at the table, and lastly public forums and specific engagement of parents using our parent-to-parent networks. The end result is that we don't have one isolated event to seek public input about the use of Office resources but rather have on-going study and action plan development, as evidenced by the following examples: The establishment of the WV Perinatal Task Force, which includes multiple

personnel from the OMCFH and the involvement of the Office Director, has developed an action plan for changes in the perinatal system. The details of the plan and the action steps are woven throughout the Block Grant materials but have included successful procurement of legislative resources and statutory changes necessary to expand metabolic screening to the 29 tests as recommended by the Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. In addition, legislation has just passed that will allow the State to establish the expectation that all medical practitioners serving pregnant women will use a risk screening instrument regardless of the woman's insurance carrier and that information will come into the OMCFH to be used for planning purposes and will affect direct patient care. Another example is the Birth to Three/Part C Early Intervention Program which has experienced such extremes in participation that the State has had to make changes in our eligibility definitions in order to keep the system solvent. Information about proposed changes were discussed with stakeholder groups, sanctioned by the Interagency Coordinating Council, and subsequently more than nine public forums were held statewide and more than 15 webinars were held. The above is provided as a confirmation of how public input and consensus building guides what we do and details of efforts are woven throughout this application. The attachment in this section includes a list of the WVMCFH advisories and members. //2010//
An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Although West Virginia has many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together a patchwork of funding streams to create a system of care for women, infants, and children, including adolescents and those with special health care needs. The WV OMCFH has developed strong partnerships across the State with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial woes. /2009/ The Commonwealth Fund Commission Scorecard recently published ranked West Virginia as number one (1) for the category of "The percent of children ages 0-17 whose personal doctor or nurse follows up after they get specialty care and the State ranked 8th in the percent of children who have a medical home. Of the four categories, WV ranked 43rd for the Potentional to Lead Long, Healthy Lives, 11th for Access, 18th for Quality and 39th in Costs. Overall on the scorecard, WV ranked 20th among the states. //2009//

/2010/ The OMCFH, like MCH programs across the country, is in a constant struggle to meet the need/demand of maternal and child health populations with limited fiscal resources. Health care inflation has seriously reduced the purchasing power of resources available to this Office.

As a consequence of the increased demand, the OMCFH has looked for every opportunity to seek non-traditional funding streams to support services for maternal and child health populations. For example, because we wanted to expand newborn metabolic screening and had the support of medical practitioners across the State, the Legislature and the Perinatal Task Force, we knew that ultimately the barrier would be money. Subsequently we designed a plan that would allow the OMCFH to bill every birthing hospital for live births at a rate established for metabolic screening services that included the work of the State Laboratory, the tracking and follow-up services of the nurses within the OMCFH, and the involvement of WVU Genetics and other medical system supports. In addition, because of the acknowledgement in our previous five year needs assessment, there was recognition that resources for family planning had not kept pace with the demand for service. We also recognized that without resources for Family Planning the lack of this preventive health opportunity would have negative implication for birth outcomes. To maximize resources, WV is now participating in the 340B Prime Vendor Purchasing Cooperative which allows us to support the Family Planning formulary at a reduced cost. The expansion of Title XXI/CHIP and the availability of Medicaid for the State's children have also allowed us to dedicate more Office resources to population-based tracking and surveillance systems that provide for early identification of children most at risk including those at risk of death in the first year of life that is determined by the statewide operation of the Birth Score system; details of the Birth Score system is elsewhere in the grant. //2010//

The West Virginia 2005 five year needs assessment indicated the following priorities in the MCH population groups:

A. Pregnant women, women of childbearing age, mothers and infants
   1. Decrease smoking among pregnant women
   2. Reduce the incidence of prematurity and low birth weight

3. Reduce the infant mortality rate

B. Children and Adolescents
1. Decrease the incidence of fatal accidents caused by drinking and driving
2. Increase the percentage of adolescents who wear seat belts
3. Reduce accidental deaths among youth 24 years of age or younger
4. Assure that children and families access health care financing and utilize services
5. Reduce smoking among adolescents
6. Reduce obesity in the State's population

C. Children with Special Health Care Needs
1. Maintain and/or increase the number of specialty providers in health shortage areas through recruitment
and credentialing.
2. Assure that children and families access health care financing and utilize service
3. Increase Newborn Metabolic Screening tests to include the 29 nationally recommended tests (this measure
has been met as of February 2009 when the expanded screening occurred).

House Bill 2583 passed during the 2007 Legislative session mandating the expansion of newborn metabolic screening to include the 29 nationally recommended tests and agreed to give the Department $460,000 to assist with start up costs. /2009/ The 2008 legislature passed newborn screening rules that established the expectation that all insurers offering infant coverage will provide reimbursement for metabolic screening services. The fee/reimbursement rate for the service is established by the Department of Health and Human Resources and based upon the cost of administering the system. The Bureau for Public Health began billing hospitals per birth in July, 2007 based on the previous years system cost, with all insurers reimbursing birthing facilities for this mandated Public Health service. //2009// ***/2010/ As of February 2, 2009, West Virginia began screening for all 29 disorders. Newborn hearing screening is a separate WV Program that began universally screening all newborns in West Virginia in 2000 before discharge from the hospital. //2010//***

/2010/ The 2008 legislative session resulted in the Office receiving additional funds to support WV's perinatal program called Right From The Start, additional monies for pharmaceuticals for Family Planning and additional fiscal resources to support Birth to Three/Part C Early Intervention. This is the first infusion of money by the State Legislature that the Office has received for more than eight years. We believe that much of the support for program expansions and additional resources are a result of many strategic partnerships that have occurred including voices and recommendations by the Perinatal Task Force, the Developmental Disabilities Council, and the RFTS Provider Network. //2010//

III. State Overview

A. Overview

West Virginia is surrounded by Pennsylvania, Maryland, Virginia, Ohio, and Kentucky and is commonly referred to as a South Atlantic state. The Appalachian Mountains extend through the eastern portion of the state, giving West Virginia the highest elevation of any state east of the Mississippi River. The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 more than 75% rural. West Virginia is the only state that lies entirely in the Appalachian Region. Even so, West Virginia is located within 500 miles of 60% of the nation's population. The state is traversed by two north/south and one east/west interstates that connect its major population centers. In addition, I-68, which ends at Morgantown, where West Virginia University is located, provides access to Washington, D.C. and Baltimore, MD. Interstate 68 also connects with Interstate 79 providing access to Charleston, WV, our state capitol. Winding secondary roads connect the majority of the state's population, with little to no public transportation available between many of the small, isolated towns. Therein lies the single most often cited issue with access to health care for many of the state's residents.

/2010/ As of October 2008, 32 of WV's 55 counties were classified as medically underserved areas with an additional 17 counties classified as partially underserved. Only five counties in the entire State were considered to have adequate medical manpower to meet the population need. The WV Board of Medicine, in 2009, reported that the current number of licensed physicians in WV is 5,705. Of this 5,705, some, while licensed, are not actively practicing. Ultimately the number of practicing physicians across the entire State is 3,739. The Board of Medicine also reports that there are 553 physician assistants. West Virginia has one School of Osteopathic Medicine and historically their physicians have established practices in our State. The Board of Osteopathy reported in May 2009, 746 D.O.s were in active practice. //2010//

A study in 1992 confirmed the numbers of obstetricians who stopped delivering babies from a previous study completed in 1989. The 1992 study, however, showed that the number of providers delivering babies had stabilized.

In 2002, The American College of Obstetricians and Gynecologists (ACOG) named West Virginia as one of nine "Red Alert" states with a looming crisis in the availability of obstetrical care, due to physicians' problems in finding or affording medical liability insurance in the state. Without liability insurance, OB/Gyns are forced to stop delivering babies, curtail surgical services, or close their doors--aggravating conditions in a state that already has many medically underserved areas. Information from ACOG surveys showed that without liability reform over half of all OB/Gyn residents planned to leave West Virginia as did a majority of private practice ob-gyns. ACOG also reported problems in recruiting new ob-gyns to the state. On March 19, 2003 ACOG applauded West Virginia lawmakers for their enactment of HB 2122, legislation to address the state's chronic medical liability insurance problems.

A third study, completed in 2006, was presented at the 2006 Perinatal Wellness Summit held in Charleston. This study showed a slight increase in the number of obstetric providers and a slight decrease in the number of births. Both the 1992 and 2006 studies showed a shortage of obstetric providers in rural areas of the state.

The 2006 study showed an increase in the number of certified nurse midwives (CNM) and a decrease in the number of family practice physicians (FP) attending births. Most of the family practice physicians who attend births are faculty in family practice residency programs.

/2010/ The WV Perinatal Task Force, which includes representatives from the OMCFH, has reported that the availability of OB/Gyns and other practitioners to do prenatal care and

delivery continues to be problematic. Not every county has sufficient births to justify labor and delivery at local hospitals making it necessary for WV women to be served outside the boundaries of our State. The Board of Medicine, in 2009, reports that there are 159 M.D.s and another 23 D.O.s delivering infants across our State. In 2007, there were 21, 917 occurrence
births in WV which is one physician for every 120 women. //2010//

/2010/ Community health centers have played a critical role in improving access to health care for all populations across WV. The community health center network is supported with state appropriations and there are multiple centers that actually receive both state and federal resources. Historically, community health center networks have received only $150,000 per year for bricks and mortar activities. In a recent meeting with Senator Jay Rockefeller we were advised that the community health centers would be able to apply for resources under the American Recovery and Reinvestment Act that would allow them to expand their physical plants. We are working with the community health centers on this issue in hopes that the physical expansion of the facility will allow them to recruit dental health practitioners. The lack of available oral health services for our adult persons in the State is a critical problem.

The OMCFH has been a strong supporter of the evolving community health center network dating back to the early 1980's. The networks at that point were struggling, and beginning in the '80's to this date we have used the community health centers to provide patient care for maternal and child health populations and used our resources to offset the cost on a fee-for-service basis. Actually the community health centers and MCFH have a symbiotic relationship that works to the mutual benefit of all, the patient, the health center and the Office. For example, the largest provider of family planning services are the community health centers.

The community health center network operates more than 106 health care sites across the State which includes school-based health centers and multiple free clinics. //2010//

/2010/ The purpose of the School-Based Health Center Program is to provide easy access to preventive and primary health care for school-age children at their local elementary, middle, or high school. These centers are operated and administered by a community-based healthcare clinic in their area.

Each center is located within the school building, or on the school campus. When the school is closed, the student may seek care at the healthcare clinic which operates their school's center.

Currently, funding is provided through the Division of Primary Care to 36 school-based health centers serving 45 schools in 18 counties, making health services available to over 25,000 students. Also, funding is provided to one more primary care organization which supplies referrals to the students at 3 high schools in their county. Additional school-based health centers are planned.

Each student receiving services at a school-based health center must be enrolled with written parental permission. Follow-up with the parent/guardian is conducted at the time of service, or immediately following.

Services which may be provided by a school-based health center include:

Preventive education
Yearly physicals
Immunizations
Chronic disease management

Check-ups
Acute and intermediate care
Oral health
Mental health
Counseling
Ancillary and enabling services
//2010//

According to 2004 Census data, 16.1% of the population in the state does not have health insurance. In March 2006, West Virginia Governor Joe Manchin lll signed legislation to expand SCHIP eligibility up to 300 percent of the federal poverty level, and on January 1, 2007, the state began a phase-in expansion by enrolling children in SCHIP with family incomes up to 220 percent of the federal poverty level. Adoption of this change is estimated to provide comprehensive health care coverage to approximately 400 uninsured children of working families during the first year of implementation. When SCHIP expands to 300% of the federal poverty level, 4,000 children are expected to be eligible. ***/2010/ WVCHIP expanded the upper income limit to cover families with incomes at 250% of poverty January 1, 2009. As of May 31, 2009, there were 24,524 children enrolled in CHIP and 154,386 children enrolled in Medicaid. //2010//***

West Virginia reached its population peak a half century ago with 2,005,552 residents counted in the 1950 census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. Four of the state's five largest cities have lost population since 1990. Charleston, the state capitol and largest city, and Huntington are the only places with populations exceeding 50,000. Population estimates from U.S. census show West Virginia among the most racially homogeneous states in the country. The 2000 census reported that 95.9% of WV residents are Caucasian, 3.5% Black or African American, 0.6% American Indian and Alaska Native, 0.7% Asian and 0.3% some other race. The ancestry of the state's population is primarily a combination of Irish and Celtic followed by a broad mixture from other European countries.

West Virginia is home to approximately 60,000 African Americans. The African American community has a rich and diverse history in West Virginia dating to the early settlement period prior to the Civil War. Some of the older communities include those in the Eastern Panhandle and around Charleston. The majority of African American communities in the state originated during the coal mining boom in the late 1800's and early 1900's. After the Civil War, many blacks left the Southern states for work in the coal mines of West Virginia. This period of relocation gave rise to many of West Virginia's older rural black communities as well as contributing to the growing communities in the larger cities.

The African American population has strong regional communities and numerous statewide organizations reflecting a network for all aspects of black culture. Individuals and groups are actively involved in the promotion of African American heritage through organizations, community events, and festivals throughout the state. In West Virginia there are African American historical societies, heritage museums, and traditional music festivals as well as community action groups, performance ensembles, academic research facilities, and arts organizations.

Spiritual life is a significant element of the black community and an important part of the history of the black community in West Virginia. Church life has been a major focus for as long as the black communities have existed. As a source of both unity and heritage, the churches provide opportunities for spiritual and social activities which regularly bring family and community together. Important church functions include day-long Sunday programs, weekly socials, and annual homecoming celebrations which provide a weekend of events for the extended church community. Most black churches have Men's Days and Women's Days which include a special Sunday morning service, a meal shared with the church community, and an afternoon of socializing. Gospel music is an important part of church and community, and West Virginia is home to several nationally recognized gospel performers and festivals. African American

churches in many communities throughout the state are involved with activities encouraging positive race relations and cross-cultural awareness.

The largest contemporary African American populations are in the Metro Valley in the vicinity of Charleston and Huntington, and in the New River/Greenbrier Valley, particularly in the vicinity of Beckley. African American communities are also found in Clarksburg, Bluefield, Fairmont, Morgantown, Parkersburg, Princeton, Weirton, and Wheeling.

West Virginia has numerous thriving Jewish communities, some of which are as old as the towns in which they are located. The members of these communities are primarily of Eastern European and German descent, and are now predominantly American-born. The first major wave of Jewish immigration occurred in the nineteenth century from approximately 1840 to 1880, mostly from Germany and Germanic states. Small but vibrant Jewish communities associated with this first period of immigration existed in Wheeling, Charleston, Huntington, and Parkersburg as early as the mid-1800's. Synagogues and Hebrew schools were soon established in the larger communities, creating a strong community focus which has helped to preserve both religious and ethnic identities up to the present. The first synagogue in West Virginia was founded in 1849 in Wheeling, the home of West Virginia's oldest Jewish community.

Events in Russia in the 1880s began the second major wave of Jewish immigrants to America, and had a profound effect on the size of the Jewish population in West Virginia. Jewish settlers from Eastern Europe came from countries such as Russia, Poland, Hungary, Latvia, and Lithuania. During the period from approximately 1888 to 1930, almost 3,000,000 Jews immigrated to America. The period also coincided with the coal boom, and many Jewish immigrant families moved into these new rural Appalachian communities in the vicinity of such towns as Beckley and Welch.

The arrival of Jews from Eastern Europe had a major impact on Jewish life in America, bringing a diversity of ethnic traditions as well as variations in religious practices. Small Jewish communities were present in most of the growing cities in West Virginia, and the new immigrants became a vital part of these existing Jewish communities. Shortly after the turn of the century some communities had two or more congregations, reflecting variations in religious practice from Orthodox to Conservative. Over the past 150 years, for example, the Northern Panhandle has had at least six congregations. Most of the larger communities in the cities have survived to the present, although Charleston is the only community which still has two congregations. There were also numerous smaller communities throughout the state, particularly in association with the mining towns. Most of these smaller Jewish communities have since folded along with the industries. The West Virginia Jewish population in general is much smaller now than it has been in the past.

Today there are numerous activities which promote heritage and strengthen bonds within the Jewish community. Religious life plays a primary role in preserving Jewish traditions and culture. A wealth of heritage is to be found in traditional Jewish services, and in community and family celebrations honoring religious holidays. These activities serve the dual role of maintaining tradition and bringing the local community together. The schedule of religious services varies from community to community, depending mostly on the size of the congregation. Larger communities hold a weekly cycle of religious services, while smaller communities might meet bi-weekly or monthly. Many of the smaller communities have services with visiting rabbis.

Today, the largest Jewish communities in West Virginia are in Beckley, Bluefield, Charleston, Clarksburg, Huntington, Morgantown, Parkersburg, Princeton, Weirton, and Wheeling. Smaller communities are still found in Logan, Martinsburg, and Williamson.

In West Virginia, the contemporary Native American population can best be described as a statewide network of individuals who claim Native American ancestry, and related organizations. There are thought to be approximately 5,000 Native Americans in West Virginia, including

individuals and from at least 80 different bloodlines and tribal associations. These include descendants from regional Native Americans, including Cherokee and Shawnee, and individuals who more recently relocated to West Virginia from throughout North America. Other people in West Virginia have Native American blood, but do not have a historical tribal association; others have mixed blood, that is, ancestry from different tribes as well as different races in addition to Native American. Tracing family history and conducting accurate genealogical research is especially challenging for those individuals.

Historically, numerous tribes traveled through the state, and many individuals escaped into West Virginia to avoid persecution and forced migration. The diverse indigenous peoples of this part of the country are sometimes collectively called the Eastern Woodland Indians. This name refers to a regional group rather than a single tribe in the traditional sense, and it reflects numerous bloodlines in West Virginia and neighboring states. Some refer to the regional group as the Appalachian Tribe. West Virginia was home and hunting territory to Shawnee, Cherokee, Delaware, Seneca, Wyandot, Ottawa, Tuscarora, Susquehannock, Huron, Sioux, Mingo, Iroquois, and other tribes. Many individuals in the state claim this heritage. Other tribes and groups represented in the contemporary community include Lakota, Blackfoot, Apache, Navaho, Choctaw, Cree, and Aztec. Members of these tribes maintain a distinct sense of identity, but are also part of the larger statewide network.

The contemporary community includes longtime residents who are finding new pride in their native heritage, and Native Americans who are newcomers to this area and who represent the pan-Indian community. The Native American community has struggled with oppression, imposed disruption, and insecurity since the arrival of European settlers in West Virginia. According to newspaper reports, individuals were being shipped away to Oklahoma reservations as late as the 1950's. Until 1965, it was considered technically illegal for a Native American to own property in West Virginia, though this law was seldom enforced. In spite of these hardships, vestiges of communities survived and their heritage is re-emerging with renewed pride.

There are numerous elders in the state who offer guidance for the community and are the bearers of older traditions, including traditional crafts and oral history. A strong reverence and protection of the elders is common among Native American communities, and this is particularly true in West Virginia.

Numerous individuals in the Native American community are involved in outreach activities, including presentations at schools. These presentations usually include song, dance, and other Native American heritage traditions. One strong tradition in the Native American community is narrative or storytelling.

The Appalachian American Indians of West Virginia (AAIWV) has approximately 4,800 members, and represents 80 different blood lines. There are four regional gatherings of AAIWV: in Delbarton (Mingo County), in Alderson (Greenbrier County), in Lumberport (Harrison County), and in Charleston (Kanawha County). There is also a monthly statewide meeting held in Summersville (Nicholas County). The organization is involved in the promotion of Native American interests at all levels in the community, including human rights issues, public awareness, education and outreach, social activities, festivals, spiritual retreats, and powwows. More information is available at http://aaiwv-ani.org/

West Virginia Native American Coalition, Inc. (WVNAMCO), a community and nonprofit organization, has approximately 65 members. Started in 1987, this group has been concerned with major issues and abuses involving Native Americans, including exploitation of cultural sites artifacts, the proliferation of incorrect information, and similar issues. They have also worked on civil rights and environmental issues, including the loss of native flora and fauna which Native American people depend upon to practice their traditional cultures. They have get-togethers, and put out flyers, newspapers, and educational materials about Native American culture.

The Organization for Native American Interests, ONAI, is an organization at West Virginia University in Morgantown. The group mainly consists of West Virginia University students and works closely with regional Native American groups. ONAI hosts the American Indian Heritage Festival and many other education events.
(WV Govenor's website).

West Virginia now has the distinction of having the oldest median age in the nation (38.1 years). West Virginia has the highest median age in the nation at 38.9, and the state's percent of people age 60 and older is ranked second in the nation. Between 1990 and 2000 people 85 and older increased by 24.8%; the number of individuals age 90 and older grew by 41. 3%. Although the population has fluctuated between 1.8 and 2.0 million over the last 50 years, the rate of births have declined from 50,000 births in 1950 to 20,000 births in 2001 dropping from a rate of 25.4 births per 1,000 to 11.3 births per 1,000. In 1997 West Virginia saw its first natural decrease, having 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. This trend continued through 2003. Because of its older population, West Virginia ranked 1st among the states in 1998 in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%). Older West Virginians value their independence, self-sufficiency and preservation of the family homestead. This lifestyle is demonstrated by the fact that residents maintain the highest percent of home ownership in the nation at 75.17%. Almost 85% of individuals age 65 and older own their home.

/2010/ In 2007, the median age of women in West Virginia was 41.8, compared with 37.9 in the U.S., 17.5% of women in West Virginia were aged 65 or older; in the U.S., 14.3% of women were 65 or older. In West Virginia, 22.9% of the female population was under the age of 20, compared with 26.3% in the U.S. In West Virginia, 94.8% of women were white, 3.4% were African American, and 1.8% were Asian or other races; in the U.S., 79.5% of women were white, 13.3% were African American, and 7.2% were Asian or other races. Only 1.0% of women West Virginia identified themselves as Hispanic; in the U.S., 14.4% of women reported being Hispanic. //2010//

/2010/ In 2006, 49.0% of state women aged 16 and older were in the labor force, compared with 58.7% in the nation. The median earnings of women in West Virgina was $25,758; in the U.S., it was $32,649 (full-time, year-round workers). In West Virginia, 16.1 % of families were headed by women (no spouse present), compared with 18.7% of families in the U.S. In West Virginia 50.6% of families were headed by women (no spouse present) with children under the age of 18 were living in poverty; in the U.S., 36.9% of such households were living in poverty.

A higher percentage of women in West Virginia (64.9%) were married or widowed than in the U.S. (58.4%). Only 21.4% of women in West Virginia have never been married, compared with 27.3% in the U.S. as a whole. //2010//

Over the past 30 years the dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are often part-time and do not include insurance plans. The low wages earned at such jobs often do not allow individuals to purchase their own health insurance coverage.

/2009/ West Virginia's unemployment rate held steady in May 2008 at 5.1% for the second year in a row. Workforce West Virginia said that the number of unemployed West Virginians increased by 100 to 42,000. West Virginia's seasonally adjusted unemployment rate was 5.3 percent in May 2008, three-tenths of a percentage point higher than the same period last year. The national jobless rate was 5.5 percent. //2009// ***/2010/ West Virginia's unemployment rate climbed to 7.8 percent in April 2009, according to Work Force WV. The number of unemployed state residents rose 2,300 to 61,000. Total nonfarm payroll employment rose 1,100 with a gain of***

2,800 in the service-providing sector offsetting a decline of 1,700 in the goods-producing sector. Within the goods-producing sector, declines of 2,100 in mining and logging and 600 in manufacturing overpowered and increase of 1,000 in construction. The service-providing sector contained a number of gains, including 1,000 in construction. The service-providing sector contained a number of gains, including 1,000 in leisure and hospitality, 800 in professional and business services, 600 in government, 400 in educational and health services, 200 in other services, 100 in information, and 100 in financial activities. Employment in trade, transportation, and utilities fell 400 over the month (April 2009).

Since April 2008, total nonfarm payroll employment has fallen 20,500, with losses of 10,700 in the goods-producing sector and 9,800 in the service-providing sector. Over-the-year gains included 1,600 in educational and health services and 900 in government. Declines included 5,800 in trade, transportation, and utilities, 5,400 in manufacturing, 4,200 in construction, 2,100 in professional and business services, 1,700 in leisure and hospitality, 1,400 in financial activities, 1,100 in mining and logging, 700 in other services, and 600 in information.

WV's seasonally adjusted unemployment rate jumped seven-tenths of percentage point to 7.5 percent, while the national rate climbed four-tenths of a percentage point to 8.9 percent as of April 2009. //2010//

Work disability is a significant problem in West Virginia. The U.S. Census Bureau states in 2000, 22.5% of the population 16-64 years of age had a disability, and 13.2% had a work disability.

Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau and reported in the State Rankings 2002 (published by Morgan Quitno), West Virginia continued to rank fifth in the nation at 17.2% of state's residents living in poverty, compared to the national average of 12.4%. In 2000 the median household income in West Virginia was $36,484. Of residents age 65 and older, 11.9% are living below the poverty level, while 16.0% of children age 18 and under are living in poverty. The percent of high school graduates or higher, of the population 25 years and over, is 75.2%.

With such a large percentage of our children living in poverty it is important that we ensure access to health care.

/2010/ Governor Joe Manchin III developed the West Virginia Kids First Screening Initiative so that children could benefit from a caring health professional working closely with their parents and school.

The Kids First Screening Initiative unites parents, health professionals and teachers to give West Virginia's children the positive start in life they deserve by working together to assure WV children entering kindergarten are healthy and ready to learn.

Every child, at first school entry, receives comprehensive screening that includes hearing, speech, language, and growth and development using the EPSDT/HealthCheck protocol. Beginning with the 2008-09 school year, all children enrolling in kindergarten will receive this wellness exam.

According to America's Promise Alliance, children need "Five Promises" to succeed in life. Since his inaugural speech in 2005, Governor Manchin asked that we unite as a state in committing ourselves to keeping these five promises for our children. The promises are:

1. Caring adults 2. Safe places 3. A healthy start 4. Effective education 5. Opportunities to

help others

The Kids First Screening Initiative is a part of keeping these valuable promises for the children of West Virginia. The Office Director of OMCFH was intimately involved in the design and development of this project. //2010//

/2010/ In the last ten years the number of cases of autism spectrum disorder has grown from one in 500 to one in 100 children across the nation. This disorder has huge implications for state governments and the health care economy. WV, like state governments across the country, is grappling with policy questions of who is going to pay, how can services be coordinated, and how can we ensure evidence-based interventions are available to families.

The last two legislative sessions, autism bills have been introduced, each time without passage. The bills had provisions requiring insurance coverage for the diagnosis. Advocates for the legislation argued that twelve states already require private health insurers to cover autism treatments. Insurance lobbyists argued that the legislation was an attempt to shift responsibility for services from school systems to the health care systems. Obviously the health and educational challenges of autism are inextricably intertwined.

State efforts in regards to this growing concern includes: 1) Part C - called West Virginia Birth To Three (IDEA);
2) Medicaid Waivers, not to be confused with a specific Autism Waiver; 3) Marshall University - Autism Training Center; 4) University based - West Virginia University (WVU) Center for Excellence in Disabilities - formerly the UAP; and 5) Education. Basically all the above are trying to address services for people with autism, but there is no master plan or coordinating body. //2010//

The Office of Maternal, Child and Family Health operates in partnership with the federal government and the State's medical community, including private practicing physicians, county health departments, community health centers, hospitals and various community agencies to address West Virginia residents' needs.

The Office of Maternal, Child and Family Health strives to provide the necessary education and access to treatment needed in order for our residents to make informed decisions regarding their own individual health needs. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's energy being used to develop systems for the provision of population-based and target specific preventive interventions, as well as infrastructure for the support of the maternal, child and family health populations.

Availability of services for West Virginia's MCFH population has increased dramatically, however, there remain areas of the State that continue to lack medical practitioners. In addition, meeting the needs of chronic or disabled populations is impaired by the lack of medical sub-specialty providers, such as occupational therapists, physical therapists, speech pathologists, dentists; and as is typical with most states, pediatric sub-specialties are mostly available at tertiary care sites. To attend to these problems, the Bureau for Public Health, in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, dentists and other specialty providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care.

/2009/ The Perinatal Partnership found that many providers, especially at small rural hospitals, complained that pregnant women and/or their newborn infants needing tertiary care were being turned away due to a lack of bed capacity at the three tertiary care centers in the State. Further study demonstrated this to be true and that the Neonatal Intensive Care (NICU) facilities have

been functioning at 100 percent capacity. Physicians with the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant transports, primarily due to no availability of NICU beds.

The Partnership's Committee on Adequacy of NICU Beds recognizes that the cost to operate NICU beds and the physical capacity of some tertiary facilities to add more beds poses problems. At the same time, it is of utmost importance to care for newborns as close to home as possible and it was recommended that the tertiary care facilities seriously study their capability to increase NICU beds. To assist in accomplishing this, it was recommended that the West Virginia Health Care Authority should immediately evaluate and update the current methodology utilized in determining Certificate of Need approval of NICU beds. The need to upgrade some community hospitals and equip them to handle newborns needing added care but not necessarily needing transfer to an NICU was discussed. Also, community hospitals can be upgraded to handle NICU "back referrals" for infants needing intermediate but not intensive care. Community hospitals that have the capacity or are willing to upgrade their capacity to accommodate infants that need added care as they transition into health are asked to begin addressing this issue.

The Perinatal Partnership noted that to avoid unnecessary admissions to NICU, each birthing facility and all maternity providers should curtail elective delivery prior to 39 weeks gestation thus implementing ACOG recommended guidelines for elective delivery. //2009//

/2010/ Between 2004 to 2007, the State's three tertiary care facilities were at NICU bed capacity with just 89 NICU licensed beds. Recently the number of beds have increased to a total of 118, although not all beds are fully functional. Between October 2007 and October 2008, 31 infants were turned away from one of the three NICU's due to lack of bed availability. This information was presented to the Legislative Oversight Committee on Health and Human Resources in an effort to increase attention to perinatal system shortcomings in West Virginia. //2010//

Legislation: West Virginia House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal, Child and Family Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the State's perinatal program called Right From The Start. The passage of the West Virginia Birth Score, in this same legislation, further strengthened the State's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk of death in the first year of life. The original birth score instrument was modified to accommodate hearing screening, so one instrument and one tracking system addresses the mandate. All WV birthing facilities began universal newborn hearing screening effective July 1, 2000. The Birth Score Office and the OMCFH newborn hearing screening project coordinator offers on-going technical assitance related to the operation of the initiative.

In 2002, three additional Bills were passed, SB 672 establishing a Birth Defects Surveillance System, HB 216 requiring screening of all children under the age of 72 months for lead poisoning, and HB 3017 requiring the creation of a state oral health program. Although all of these programs existed previously, legislative mandates ensure continuance of these health efforts. The Birth Defects Surveillance Program and the Childhood Lead Screening Program are largely supported by grants from the Centers for Disease Control (CDC). Rules for the Birth Defects Surveillance Program and the Childhood Lead Poisoning Prevention Program were passed by the 2004 Legislature.

/2010/ The 78th West Virginia Legislature, passed in the 2007 session, H. B. 2583 mandating the expansion of newborn screening to include 29 disorders. The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, partnered with the State Laboratory to expand

newborn screening to include the twenty-nine (29) disorders in order to adhere to national standards recommended by the United States Department of Health and Human Services Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. The Bureau for Public Health submitted legislative rules that allowed for financial sustainability by invoicing the hospitals for each live birth receiving a screen. The fee charged is based on cost and will be sufficient to cover the cost of the newborn metabolic system. Screening for all 29 newborn disorders became effective February 4, 2009. //2010//

/2010/ On April 1, 2009, states began to receive education and childcare funds appropriated under the American Recovery and Reinvestment Act. Several states, including West Virginia, want to use the money to improve childcare, and information technology so longitudinal data about school enterers is available for planning purposes.

West Virginia will be purchasing Ages and Stages for use by childcare, medical practitioners, and the IDEA/Part C system to improve early identification efforts of children experiencing delay. There is also discussion about monies being dedicated to quality improvement in early childhood care centers, since three quarters of the nation's children between the ages of 3 and 5 and more than half of the children ages 2 and under spend time in some form of non-parental care. Many of these children are cared for by relatives, but a large proportion -- 57% of children aged 3 to 5 and 20% of infants and toddlers are in center-based care. The quality of care in childcare settings varies dramatically, with low income children generally receiving the lowest quality care. We see the voluntary participation in statewide Quality Rating and Improvement Systems the best way to improve the overall level of quality.

Childhood is a unique and valuable stage in the human life cycle. The most important influence in the life of a young child is the family. Parent education and home visiting programs strengthen the family and support parents. Many early childhood home visiting programs focus on families who are at risk, such as young, first-time mothers, mothers of low birthweight infants and low income families. West Virginia RFTS Program focuses on low income, medically high risk pregnant women…its goal is improving pregnancy outcome and infant well-being, and is managed by the OMCFH in partnership with licensed nurses and social workers employed by community-based agencies statewide. BTT, while not a home visiting program, also serves 98% of the eligible population of developmentally delayed infants and toddlers under age three years in their home. This Program is considered educational in nature, has no income guidelines, and is for a subset of the population. Nevertheless, BTT (Part C/IDEA) is an investment in early childhood, administered under the U.S. Department of Education/Office of Special Education Programs' guidelines by the OMCFH.

Other home visiting programs in West Virginia support parents and caregivers in preparing children for school entry and lower risks associated with growing up in poverty. The multiple programs serving early childhood populations provide unique opportunities for overall improvement in child and family well-being. Fortunately, no one program is expected to serve the total population of children birth to six years of age. On the downside, there is often competition for scarce fiscal resources and confusion about what constitutes a home visiting program compounded by service competition for populations; i.e., pregnant women.

Parent Education and Home Visiting Appropriation for WV, not including RFTS and BTT: 2007-$482,000 and 2008 $732,000.

In 2008, there were 62,648 infants and toddlers statewide between the ages of birth to three. Aggregate count of children served by the State's BTT Prgram between July 1, 2008 and June 30, 2009 statewide was 5,734. //2010//

Following is a Vital Statistics Summary:

/2010/ Population

In 2007, 950 West Virginians were added to the total population as a result of natural increase, the excess of births over deaths. The rate of natural increase was 0.5 persons per 1,000 population. Results from the 2007 Census estimate show an overall increase (approximately 0.2%) in the state's population since 2000, from 1,808,344 to 1,812,035. This increase is the result of a slight growth in the excess of in-migration over out-migration during that span, as well as the natural increase.

Live Births

West Virginia's resident live births increased by 1,086 or 5.2%, from 20,931 in 2006 to 22,017 in 2007. The 2007 birth rate also increased 6.1% from 11.5 per 1,000 population in 2006 to 12.2. The U.S. 2007 birth rate was 14.3 live births per 1,000 population rising slightly above the 2006 rate of 14.2. As the graph below shows, West Virginia's birth rate has been below the national rate since 1980. It continued its overall decline until 1996, interrupted by slight upturns in 1989 through 1991. It remained relatively stable from 1996 to 2006 until this year's increase.

The 2007 U.S. fertility rate of 69.5 live births per 1,000 women aged 15-44 was slightly higher (1.5%) than the 2006 rate (68.5). West Virginia's fertility rate increased 6.2%, from 59.3 in 2006 to 63.1 in 2007. The fertility rate among women aged 15-19 in West Virginia was 11.3% higher than that among young women in the U.S. (47.3 vs. 42.5). The fertility rate among women aged 20-44 was lower by 11.6% in the state than in the nation (66.0 vs. 74.7).

The number of births to teenage mothers (ages 10-19) increased by 135 (5.2%), from 2,602 in 2006 to 2,737 in 2007. The percentage of total births represented by teenage births was the same at 12.4% for 2006 and 2007. The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than was found nationally (10.5% in 2007).

The percentage of births occurring out of wedlock continued to rise in 2007. Now, two of every five (40.3%) West Virginia resident births were to unwed mothers. The percentages of white and black births that occurred out of wedlock in West Virginia in 2007 were 39.2% and 73.4%, respectively, compared to 36.7% and 73.5% in 2006. In the United States in 2006, 26.6% of white births (non-Hispanic) and 70.7% of births to black mothers (non-Hispanic) occurred out of wedlock. The percentage of teenage births to unmarried teenage mothers in the state increased from 78.1% in 2006 to 80.8% in 2007.

There was a total of 2,094 low birthweight babies (those weighing less than 2,500 grams or 51/2 pounds) born to West Virginia residents in 2007, 9.5% of all births. Of the 2,094 low birthweight infants, 1,413 or 67.5% were preterm babies born before 37 weeks of gestation. (Of all 2007 resident births with a known gestational age, 12.5% were preterm babies.) Of the births with known birthweight, 9.3% of babies born to white mothers and 14.9% of babies born to black mothers were low birthweight. Nationally, 8.3% of all infants weighed less than 2,500 grams at birth in 2006; 7.3% of white infants and 14.0% of black infants were of low birthweight.

Eighty-two percent (82.0%) of 2007 West Virginia mothers with known prenatal care began their care during the first trimester of pregnancy, compared with 86.1% of mothers nationwide in 2005 (the latest data available). Among those with known prenatal care, 82.5% of white mothers began care during the first trimester; 71.9% of black mothers did so. (U.S. figures show that 86.7% of white mothers and 76.5% of black mothers had first

trimester care.) No prenatal care was received by 0.6% of white mothers and by 0.9% of black mothers.

Over one-fourth (26.8%) of the 22,017 births in 2007 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol. National figures from 2005 show that 10.7% of women giving birth reported smoking during pregnancy; 0.8% used alcohol in 2004 (the latest data available). Among the state mothers who reported smoking during pregnancy, 14.2% of the babies born were low birthweight, compared with 7.8% among non-smoking mothers. Over one-third (35.6%) of 2007 state births were delivered by Cesarean section, compared with a 2006 national rate of 31.1%. One or more complications of labor and/or delivery were reported for 31.6% of deliveries in the state in 2007.

Deaths

The number of West Virginia resident deaths increased by 418, from 20,649 in 2006 to 21,067 in 2007. The state's crude death rate rose from 2006 at 11.4 per 1,000 population to 11.6 in 2007. The average age at death for West Virginians was 72.0 (68.4 for men and 75.6 for women), slightly lower than the 2006 average of 72.1 (68.4 for men and 75.7 for women). One hundred and twenty-three West Virginia residents who died in 2007 were age 100 or older. The oldest woman was 108 years old at the time of death, while the oldest man was 106 years old.

Heart disease, cancer, and chronic lower respiratory diseases, the three leading causes of death, accounted for 53.5% of West Virginia resident deaths in 2007. Compared with 2006, the number of state deaths due to heart disease decreased 1.1% while cancer deaths increased 1.6%. Chronic lower respiratory disease, which was the third leading cause for the seventh time in the past eight years, increased 7.1%; while stroke mortality increased by seven deaths (0.6%). Diabetes mellitus deaths increased 7.4%, while the number of reported deaths due to pneumonia and influenza decreased 6.3%. Dementia, now the seventh leading cause of death in the Mountain State, increased 10.2% while Alzheimer's disease increased 3.7%. Unintentional injury mortality was the fourth leading cause of death. The number of unintentional injury deaths rose by 37 (3.1%), from 1,205 in 2006 to 1,242 in 2007. Motor vehicle accident deaths only increased by three, from 422 in 2006 to 425 in 2007. Accidental poisoning deaths have been on the rise in West Virginia for the past six years, remained the same in 2007 and 2006 at 406 deaths. The vast majority of these deaths were due to both legal and illicit ingestion of prescription pharmaceuticals.

Unintentional injuries were the leading cause of death for ages one through 44 years. Motor vehicle accident fatalities remained the single leading cause of death for young adults aged 15 through 24, accounting for 34.7% of all deaths for this age group in 2006. West Virginia's 2007 motor vehicle fatalities included six children under five years of age, same as 2006. Accidental poisoning accounted for over one-fourth (25.6%) of all deaths in the age group of 25-34.

Suicides increased by 30, from 282 to 312 between 2006 and 2007. Male suicides increased by 36 or 16.0 %, from 225 in 2006 to 261 in 2007; the number of female suicides (51) increased by six or 10.5% from 2006. Over two-thirds (67.6%) of all suicide deaths were firearm related -- 73.2% of male suicides and 39.2% of female suicides. The average age of death for a suicide victim in 2007 was 47.0 years. While suicide was the 12th leading cause of death overall, it was the third leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under was nine in 2007, down from 14 in 2006.

Homicides decreased by nine, from 103 in 2006 to 94 in 2007. Sixty-four (64) of the homicide victims were male, 30 were female. The average age at death for a homicide

victim in 2007 was 34.5 years. There were 11 homicide victims under the age of five in 2007, compared with only one in 2006. Over half (52.1%) of 2007 homicide deaths were due to firearms.

Years of Potential Life Lost (YPLL)

YPLL is a measure of mortality, calculated as the difference between age 75 (an average life span) and the age at death. Using YPLL before age 75, the sum of YPLL across all causes of death represents the total YPLL for all persons dying before the age of 75. A person dying at the age of 45 would therefore contribute 30 years to the total YPLL (75-45=30). YPLL is an important tool in emphasizing and evaluating causes of premature death.

The YPLL from all causes increased 3.7%, from 167,481 YPLL in 2006 to 173,739 in 2007. The four leading causes of YPLL in 2007 were malignant neoplasms (35,864 YPLL), diseases of the heart (25,379 YPLL), non-motor vehicle accidents (20,614 YPLL), and motor vehicle accidents (14,554 YPLL). Combined, these four causes accounted for over half (55.5%) of all years of potential life lost in 2007. In comparison to 2006, YPLL attributable to malignant neoplasms decreased from 21.1% to 20.6%. YPLL due to diseases of the heart decreased from 14.8% to 14.6% of the total, and YPLL due to non-motor vehicle accidents decreased from 12.3% to 11.9%. The percentage of total YPLL due to motor vehicle crashes also decreased, from 8.7% to 8.4%.

Infant Deaths

Deaths of infants under one year of age rose by eight, from 155 in 2006 to 163 in 2007. However, West Virginia's infant mortality remained the same at 7.4 per 1,000 live births in 2006 and 2007. The U.S. infant mortality was 6.9 in 2006 (the latest data available).

The state's 2007 white infant mortality rate increased slightly, from 6.8 in 2006 to 6.9, while the rate for black infants decreased from 29.2 to 22.0 (see Statistical Variation in B, page 173. West Virginia's 2007 race-specific infant mortality rates and comparable 2006 U.S. rates are shown in the table on the following page.

Over one out of six (17.8%) infant deaths in 2007 were due to SIDS (sudden infant death syndrome). Approximately one in six (16.6%) were the result of congenital malformations, while 49.1% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (10.4%).

Neonatal/Postneonatal Deaths

The number of neonatal deaths rose by 22, from 81 in 2006 to 103 in 2007; the neonatal death rate also increased, from 3.9 deaths among infants under 28 days per 1,000 live births in 2006 to 4.7 in 2007. Neonatal deaths comprised 63.2% of all West Virginia resident infant deaths in 2007, compared with 52.3% in 2006. The rate of postneonatal deaths decreased from 3.5 deaths per 1,000 neonatal survivors in 2006 to 2.7 in 2007. The 2006 U.S. neonatal death rate was 4.6, while the postneonatal rate was 2.3 deaths per 1,000 neonatal survivors. U.S. neonatal and postneonatal data for 2007 were not available at the time of this publication.

Fetal Deaths

The 116 resident fetal deaths occurring after 20 or more weeks of gestation reported in 2007 were four less than in 2006 (120). The fetal death ratio also decreased, from 5.7 deaths per 1,000 live births in 2006 to 5.3 in 2007. The majority (93.1%) of fetal deaths were due to conditions originating in the perinatal period, including complications of

placenta, cord, and membrane (34.5%), maternal conditions (2.6%), maternal complications (10.3%), short gestation and low birthweight (7.8%), and other ill-defined perinatal conditions (25.9%). Congenital anomalies accounted for 6.9% of all fetal deaths.

Induced Termination of Pregnancy (ITOP)

The annual reporting of induced termination of pregnancy (ITOP), also properly referred to as "induced abortion," was mandated in the latest revision of the West Virginia Code. An ITOP is a purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant and which does not result in a live birth. The management of prolonged retention of products of conception following fetal death is excluded. The major distinguishing feature of this event is the fact that it is "purposeful" rather than spontaneous. A spontaneous interruption of a pregnancy is also known as a fetal death or a spontaneous abortion or, more commonly, as a miscarriage or a stillbirth.

One of the primary differences between the reporting of ITOP data and birth and death statistics is that ITOP statistics reflect events that occurred in West Virginia. Due to long standing interjurisdictional exchange agreements with the other states, births and deaths to West Virginia residents that occur elsewhere are reported back to West Virginia, making it possible to ascertain the number of births and deaths among West Virginia residents in a given time frame regardless as to where the event occurred. Information on the number of West Virginia residents who obtain an ITOP in another state is infrequently reported back to West Virginia by the state where the procedure took place, normally due to restrictions within the other state's legal code.

The only two free-standing clinics that perform ITOPs on demand in West Virginia are in Charleston, which makes the likelihood of out-of-state ITOPs greater in some regions of the state. It is unlikely that the majority of women living in the northern or eastern panhandles of the state seek an ITOP in West Virginia. Due to known incomplete reporting, therefore, the procedures performed on West Virginia residents in other states have been excluded from the compiled statistics.

In 2007, there were 1,849 ITOPs performed in West Virginia, 9.2% less than in 2006 (2,037). Nearly nine out of every ten (89.7%) 2007 ITOPs involved a West Virginia resident, while 5.8% were Ohio residents and 3.7% were residents of Kentucky, compared with 2006 percentages of 89.7%, 5.4%, and 3.8%, respectively. The median age of women having an ITOP in 2007 was 23, compared to 23 in 2006. There were 122 procedures in 2007 involving females under the age of 18, of which 119 were to unemancipated minors compared with 108 in 2006, of which 100 were unemancipated minors.

Declaration of Paternity Affidavit

A declaration of paternity affidavit, commonly called a paternity affidavit or a paternity acknowledgement, is a legal instrument signed by both parents in which both attest to the paternity of their child. In most situations, paternity affidavits are used when the mother was unmarried at the time of conception or birth. It is unlawful to file a certificate of live birth with a father for a birth to a woman who was unmarried at the time of conception or birth without having first received an acceptable declaration of paternity affidavit or an order from the court of competent jurisdiction. Under West Virginia State Code and, generally, nationwide, the husband of a woman at the time of conception or birth of her child is presumed to be the legal father of the child. Until July 2006, the birth certificate for a child born in wedlock could only bear the name of the mother's husband unless there was a court order that specified otherwise. In July 2006, an administrative procedure was put in place to allow a mother, her husband, and a putative father to attest that the husband was not the father and that the putative father was the biological father. This "three-way" paternity process is in use in over half of the states in the nation.

There were 21,917 babies born in West Virginia during 2007. Of those, 9,076 or 41.4% were born to unmarried mothers, compared with 39.0% in 2006. A father was established through a paternity affidavit in 6,079 or 67.0% of the unmarried births (27.7% of all occurrence births) in 2007, compared with 65.3% of unmarried births or 25.5% of all births in 2006.

Marriages

For the first time in seven years, the number of marriages in West Virginia increased, from 13,276 in 2006 to 13,308 in 2007. The marriage rate in 2007 was 7.3 per 1,000 population, same as 2006. The 2007 U.S. provisional rate was 7.3.

For all marriages in 2007, the median age was 26 for brides and 29 for grooms. For first marriages, the median age for brides was 22; for grooms it was 24. The mode (most frequently reported age) for all marriages was 23 for brides and 24 for grooms, while for first marriages the mode was again, 23 for brides and 24 for grooms.

Divorces and Annulments

The number of divorces and annulments increased by 114 or 1.2%, from 9,191 in 2006 to 9,305 in 2007. The 2007 rate of 5.1 per 1,000 population was the same as the 2006 rate.

Of the 9,305 divorces in West Virginia in 2007, the median duration of marriage was six years. Over half (52.3%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 23.5% of all divorces and two children were involved in 18.0%. Two divorces involved six or more children.

Summary

The number of West Virginia resident births increased by 1,086 from 20,931 in 2006 to 22,017 in 2007. West Virginia resident deaths increased by 418 (20,649 in 2006 to 21,067) in 2007. The number of infant deaths rose by eight, from 155 in 2006 to 163 in 2007. Fetal deaths of 20 or more weeks gestation decreased from 120 in 2006 to 116 in 2007. Marriages increased for the first time in seven years, from 13,276 in 2006 to 13,308 in 2007, while divorces also increased from 9,191 in 2006 to 9,305 in 2007. Abortions in West Virginia dropped from 2,037 in 2006 to 1,849 in 2007. A father was established through a paternity affidavit in 6,079 (or 27.7%) of the births occurring in West Virginia. This is only the third year for which data on induced termination of pregnancy and paternity affidavits have been included. //2010//

/2010/ According to Child Maltreatment 2007, in 2006 there 15 child fatalities due to maltreatment, 6 of which were in the Child file as Child Protective Services (CPS) cases in WV. This represented a rate of 3.86 deaths per 100,000 children ages 0-17. The national average for 2006 was 2.05. In WV in 2007 there were 12 child fatalities due to maltreatment of which 8 were in the Child file as CPS cases. For WV this represented a rate of 3.10 deaths per 100,000 children ages 0-17.

Also according to Child Maltreatment 2007, in 2007, WV had a total of 7,109 victims of reported child maltreatment. Of these, 973 or 13.7% were removed from the home. There were a total of 42,248 non-victims in the homes of which 700 or 1.7% were removed from the home. In total there were 1,673 children removed from their home in 2007. Of the 7,109 children reported as victims of maltreatment 639 or 9% were children with disabilities. Of the 639, 74% were children with a behavior problem and 33% were children who were emotionally disturbed. (Percentage does not equal 100% as some children had both disabilities).

On Absence of Maltreatment Recurrence between 2004-2007, WV has typically stayed around 88% each year with the national standard set at 94.6%. In 2004, 17 states met the national standard and in 2007 24 states met the national standard. Only 5 states were in the high eighties percent range, which included WV, while the rest of the reporting states were in the nineties. //2010//

B. Agency Capacity

The Office of Maternal, Child and Family Health has historically purchased and/or arranged for health services for low income persons, including those who have health care financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments and recruited physicians to serve mothers and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

Income eligibility coverage for pregnant women is 185% of the Federal Poverty Level in response to patient demand, using Title V monies. Although the Office of Maternal, Child and Family Health is less and less involved as a health care financier, we continue to provide gap filling services when indicated.

The OMCFH is constituted of three divisions, plus a Quality Assurance/Monitoring Team, Provider Education and Recruitment Unit, Early Intervention IDEA/Part C, and an Administrative Unit. With the exception of the Children with Special Health Care Needs Program, the Office of Maternal, Child and Family Health does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for West Virginia women and men of reproductive age, infants, children, adolescents, and children with special health care needs.

Division of Perinatal and Women's Health:
The focus of the Perinatal and Women's Health Division of the Office of Maternal, Child and Family Health is to promote and develop systems which address availability and accessibility of comprehensive health services for women across the life span and high risk infants in the first year of life. Administrative oversight includes an integrated perinatal care and education system paid for by Title V and Title XIX. Perinatal and Women's Health programs include the Family Planning Program under which the Adolescent Pregnancy Prevention Initiative is housed; the Breast and Cervical Cancer Program; and the Right From The Start (RFTS) Perinatal program that includes the Birth Score Project. Additionally, these programs provide linkage and referral to other women's, infant's, and children's services. The goal of this Division is to improve the health status of all women and infants up to one year of age, and to reduce the infant mortality rate.

Family Planning Program:
The Family Planning Program (FPP) provides an array of confidential preventive health services for low-income women, men and adolescents through community-based provider network of /2009/ 148 locations //2009//. Sites include county health departments, primary care centers, hospital outpatient centers, private providers, free clinics and university health sites. FPP services include contraceptives; health histories; gynecological exams; pregnancy testing; screening for cervical and breast cancer; screening for high blood pressure, anemia, and diabetes; screening for STDs, including HIV; basic infertility services; health education and counseling, and referrals for other health and social services. Free or low cost pregnancy testing is offered to enable early identification of pregnancy and timely referral into prenatal care.

For more than three decades, the WV Family Planning Program has been an integral component of the public health system, providing high-quality reproductive health services and other preventive health care to low-income or uninsured individuals who may otherwise lack access to health care. Subsidized medical care provided by Family Planning Program clinics prevents unintended pregnancies, reduces the need for abortion, lowers rates of sexually transmitted diseases, including HIV, detects breast and cervical cancer at its earliest stages and improves the overall health of women, children and families.

Any female or male capable of becoming pregnant or causing pregnancy whose income is at or below 250% federal poverty level is income eligible to receive free or low-cost clinical examinations and free contraceptives through the Family Planning Program. Among the 50 States and the District of Columbia, West Virginia ranked 6th in the availability of publicly funded contraceptive services. These publicly funded clinics help women prevent 13,800 unintended pregnancies each year.

/2010/ In 2006, surgical sterilization services were suspended due to inadequate funding and a waiting list of clients requesting voluntary surgical sterilization procedures was kept at each provider site. The 2007 WV legislature authorized an additional 1.4 million for family planning services to again offer sterilization services to persons meeting federal guidelines. //2010//

Adolescent Pregnancy Prevention Initiative:
The Adolescent Pregnancy Prevention Initiative (APPI) provides development, oversight and coordination of adolescent pregnancy prevention activities. As a focus area of the Family Planning Program, the goal of the Adolescent Pregnancy Prevention Initiative is to reduce the number of pregnancies among adolescents through improved decision-making skills, abstinence, and/or access to contraceptive services.

APPI is made up of 5 full-time employees: 1 Coordinator and 4 Adolescent Pregnancy Prevention Specialists, who conduct community education and outreach activities on a regional/local level. These 4 Adolescent Pregnancy Prevention Specialists work to increase public awareness of problems associated with early sexual activity and childbearing and collaborate with existing community organizations to promote local activities for adolescent pregnancy prevention. APPI offers abstinence based education but includes information about contraceptives and access to family planning services.

Confidential access to Family Planning Program services is crucial in helping sexually active teenagers obtain timely medical advice and appropriate medical care to continue the decline in teen pregnancy and childbearing. Minor clients seeking reproductive health care can only be assured of confidential services by a Title X-funded Family Planning Program network provider. Current research documents show that fewer teens will seek preventive reproductive health services if confidential care, without parental consent, is not available.

Preconceptual Services:
Preconception care is a critical component of health care for women of reproductive age. The primary goal of preconception care is to provide health promotion, screening, and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Preconception health care is critical because several risk behaviors and exposures affect fetal development and subsequent outcomes.

Family Planning Program clinics offer counseling and referral for patients regarding future planned pregnancies, management of current pregnancies, or other individual concerns (i.e., nutrition, sexual concerns, substance use and abuse, sexual abuse, domestic violence, or genetic issues). FPP clients seeking pregnancy or planning a pregnancy in the future are offered prenatal muti-vitamins with folic acid as part of their pre-conceptual counseling. Clients in need of

enhanced preconception counseling or genetics testing are referred to tertiary care facilities or specialty providers for additional assessment.

Domestic Violence:
Screening for Domestic and Intimate Partner Violence continues to be monitored by the Family Planning Program. Findings are documented in their reports and entered in a data base. All Family Planning Program providers provide resources on site for services to those who are victims of domestic or intimate partner violence. ***/2010/ The Family Planning Program is required by the federal Title X regulations to educate every minor client about sexual coercion and counsel on actions to resist this type of assault. The FP Program has statewide protocols on this topic for particpating providers and every new client, who is a minor, receives a copy of "Trust Betrayed". The "Trust Betrayed" booklet was originally developed by the WV Coalition Against Domestic Violence. OMCFH assisted with editing some content, then we have historically paid for reprinting. In addition, FP Program providers are required to adhere to State reporting laws on child abuse, child molestation, sexual abuse, rape or incest.***

The Director of Perinatal Programs participates on the WVDHHR Domestic Violence Workgroup. The workgroup continues to explore development of a statewide tool to be used to screen for domestic violence. The committee is near the finalization in writing the State Public Health Plan for Reducing Domestic Violence through public education, use of media and collection, and monitoring and presentation of State data. The RFTS Project screening tool and the Initial Client Assessment, was shared with the workgroup. The tool includes questions that are used to screen RFTS pregnant women for domestic violence during home visits. In 2008, the fifth top risk factor disclosed by RFTS Project participants was domestic violence. //2010//

Insurance/Access:
The Family Planning Program has been an integral component of the public health care system, providing high-quality reproductive health services and other preventive health care to low-income or uninsured individuals who may otherwise lack access to health care. Subsidized preventive and reproductive medical care provided by Family Planning Program clinics prevents unintended pregnancies, reduces the need for abortion, lowers rates of sexually transmitted diseases (STDs), including HIV, detects breast and cervical cancer at its earliest stages, and improves the health of women, children and families.

Right From The Start Project:
/2009/ Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. West Virginia's RFTS Project was birthed in 1989 as a partnership between OMCFH and West Virginia Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-income women up to sixty (60) days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. RFTS also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a West Virginia resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

Through the RFTS Project, OMCFH fulfills this oversight responsibility by assuring:
•Availability of medical providers who agree to provide care in accordance with American College of Obstetricians and Gynecologists (ACOG) Standards of Care;
•Availability of licensed practitioners credentialed to provide care coordination and patient

education for low-income women with high risk of adverse pregnancy outcomes or for low-income families with infants at risk of poor health or death;
•Technical assistance to RFTS providers; and
•Quality assurance monitoring and improvement to assure government sponsored patients receive care provided in accordance with national standards.

/2010/ Right From The Start has Letters of Agreement with approximately 69 community agencies throughout WV to provide care coordination and enhanced education services to high risk pregnant women and infants. These services are provided by registered nurses and licensed social workers, called Designated Care Coordinators (DCC), employed by the community agencies.

The State is divided into eight (8) regions for management of RFTS. Each region has a Regional Lead Agency (RLA) that provides a Regional Care Coordinator (RCC) to oversee the activities of the Designated Care Coordinators (DCC). In addition to assigning patient referrals and promoting the project, the RCC coordinates training and education for DCC staff, and recruits obstetrical care providers and designated care coordination agencies.

Currently, there are 185 DCCs dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there are sixty-nine (69) obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have Letters of Agreement with the Project to provide quality obstetrical and delivery care to pregnant women.

Each RFTS prenatal client is assessed for depression at least once during the prenatal period and again within the postpartum period prior to case closure at 2 months postpartum. The standard tool used by the RFTS Project to assess the prenatal client's mental status is the Edinburgh Postpartum Depression Screen (EPDS). The DCC has established guidelines regarding the numerical score which triggers a mandatory mental health referral.

In 2008, 4,394 RFTS Project participants were screened for depression using the EPDS. 2,731 women were screened in the prenatal period and 1,663 women were screened during the postpartum period. A significant number of women had positive EPDS levels and were referred for assistance. RFTS data for 2008 show 62% of enrolled pregnant women qualify for Intensive Level of Care. According to Project protocol, the determinants of care that qualifies a pregnant woment for "Intensive Level" include: high conflict with significant other, a history of family violence/physical abuse and lacking a support system in times of stress.

The RFTS website, launched January 11, 2007 has generated many inquiries from the email account at both state and regional levels. Inquiries have been received by women interested in becoming Project participants as well as individuals and/or medical providers interested in becoming Project providers. In 2008 the website was updated to reflect program announcements and provider changes. For access, the web address is www.wvdhhr.org/rfts. //2010//

RFTS SCRIPT:
/2010/ West Virginia continues to have the highest rate of pregnant smokers in the U.S. During 2007, 26.9% of WV births were to women that smoked. Forty point five percent (40.5%) of Medicaid insured pregnant women smoke while 12.4% of non-Medicaid insured pregnant women smoke. To address this issue, RFTS adopted an intense smoking cessation initiative, the WV Right From The Start SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment). SCRIPT was developed by Dr. Richard Windsor, MS, PhD, MPH, George Washington University Medical Center, Department of Prevention and Community Health, who successfully implemented the program in Alabama. The RFTS SCRIPT

Program uses the 5 A's (Ask, Assess, Advise, Assist, Arrange), best practice method for smoking cessation education with pregnant women supported by the Treating Tobacco Use and Dependence: Clinical Practice Guideline, Agency for Healthcare Research and Quality and by the American College of Obstetricians and Gynecologists Bulletins, 2000, 2005 //2010//.

The smoking cessation program was implemented statewide in West Virginia in January 2002, through the OMCFH and incorporated as protocol into the RFTS Project in October 2003. The WV RFTS SCRIPT uses the existing home visitation network and protocols established in the RFTS Project. Registered nurses and licensed social workers, DCCs, provide services to pregnant women and infants throughout West Virginia.

Data from the RFTS Project show the following quit rates among pregnant participants:
2003 = 23%; 2004 = 22%; 2005 = 26%; 2006 = 27%; 2007 = 22%

ART:
/2009/ Access to Rural Transportation (ART) provides payment for transportation of RFTS Maternity Services eligible clients to medical or other predetermined medical care appointments (i.e. childbirth classes). The provision of transportation assistance is important to the goal of improving pregnancy outcomes and to the wellness of women and infants in West Virginia.

RFTS Maternity Services clients receive transportation assistance via the ART system while Medicaid eligible clients receive transportation via the Non-Emergency Medical Transportation (NEMT) system. //2009//

Birth Score:
/2010/ High risk infants are referred to RFTS by the WVU, Birth Score Program. The Birth Score Developmental Risk/Newborn Hearing Screen Instrument is a population-based assessment designed to identify infants at birth that may be at risk for developmental delay or death within the first year of life. Infants who are identified as high risk receive an accelerated number of six medical visits in the first six months of life. Other Medicaid-sponsored infants who are considered at risk are referred to RFTS from various sources for care coordination.

In 2007, the Birth Score Developmental Risk/Newborn Hearing Screen Instrument was revised and questions added pertaining to the mother's oral health and substance abuse during pregnancy. The numerical Birth Score was changed so that the newborn is considered High Birth Score if the score is 99 or greater. All WV birthing sites implemented the new Birth Scoring System August 1, 2007. All High Birth Score infants continue to be referred to the RFTS Project for care coordination from birth through age one year.

By December 31, 2008 there were 817 active primary care providers (599 private physicians and 218 clinics) accepting Birth Score referrals. There were 42 new providers added in CY 2008.

The Birth Score Office published a report released November 19, 2008 entitled "A Descriptive Analysis of RFTS Prenatal Services, WV 2007". This report provides an analysis of the differences found between 4,547 government sponsored women who were referred for RFTS prenatal services and/or received RFTS prenatal services in CY 2007 and 7,539 government sponsored (Medicaid) women who were not referred for RFTS prenatal services in CY 2007. This report also describes the differences found between the referred women who received at least one RFTS prenatal service in 2007 and the referred women who received no RFTS prenatal service in 2007. //2010//

Breast and Cervical Cancer Screening Program:
The West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) is a comprehensive public health program that assists uninsured/underinsured, low income women (at or below 200% of the Federal Poverty Level) between the ages of 25 and 64 in receiving quality breast and cervical cancer screening services. These services are offered through a statewide network of over 300 screening and referral providers. The WVBCCSP is funded through a federal cooperative agreement with the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). West Virginia was one of the original eight states which received funding to implement this program in 1991. Today, the NBCCEDP spans all fifty states and the District of Columbia, five U.S. territories, and twelve American Indian/Alaska Native organizations.

/2010/ Since its inception, the WVBCCSP has enrolled over 110,000 women into the Program and provided more than 141,500 mammograms, 208,500 clinical breast exams, and 218,000 Pap tests. Annually, the Program screens over 16,000 women. However, the Program does more than simply screen women. There are several core components of the WVBCCSP including: Program Management; Screening, Tracking and Follow-up; Surveillance/Data Management; Quality Assurance and Improvement; Professional Development; Recruitment; Partnerships; and Evaluation. //2010//

/2009/ West Virginia's WISEWOMAN Program is a comprehensive public health program that works with the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) to provide women access to screening services to determine their risk of heart disease and stroke. WISEWOMAN is directed at low-income, uninsured/underinsured women aged 40-64 years. As part of a WVBCCSP eligible woman's routine breast and cervical cancer screening exam, she will be provided blood pressure readings, total and HDL cholesterol screening, blood glucose measurements, calculation of body mass index, assessment of smoking status, and evaluation of personal and family medical history. As follow-up to her screening exam, she will be offered risk reduction counseling and lifestyle interventions that will address nutrition, physical activity and tobacco use. //2009//

/2010/ Contracted providers and WISEWOMAN staff ensure that women with abnormal screenings receive timely follow-up through the active monitoring of Program data. The WISEWOMAN Grant provides $750,000 in funds. The majority of provider sites are community health centers, since their federal assignment is assuring health access, and this provides an opportunity to be identified as the woman's health home. //2010//

In 1996, the West Virginia Legislature enacted House Bill 4181, establishing the Breast and Cervical Cancer Diagnostic and Treatment Fund for the purpose of assisting medically indigent patients with certain diagnostic and treatment costs for breast and cervical cancer. The Fund provides resources to offset the cost of diagnostic care not otherwise available to the WVBCCSP through the federal cooperative agreement.

To assist NBCCEDPs in providing treatment to women diagnosed with breast and/or cervical cancer, the 2000 Congress gave states the option to provide medical assistance for treatment through Medicaid as a part of the passage of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). West Virginia was one of the first states to take advantage of this opportunity. This means that when an uninsured woman under the age of 65 is diagnosed with breast and/or cervical cancer and/or certain precancerous conditions, she is eligible for a Medicaid card. The card will pay for all her health care services that are included in the Medicaid State Plan, not just those to treat the cancer diagnosis.

Division of Infant, Child and Adolescent Health:
The goal of this Division is to promote parent/professional collaboration through parent participation on advisories; develop and issue medical care protocols in collaboration with the medical community to ensure provision of quality community-based services for child populations;

and develop patient education and outreach strategies to encourage use of preventive health care.

Adolescent Health Initiative (AHI):
/2010/ This program, originally financed solely by Title V, to address the most prevalent health risks facing adolescents today, has become a part of a larger initiative within OMCFH financed by TANF resources. The primary goal of the AHI is to improve the health status, health related behavior, and availability/utilization of preventative, acute, and chronic care services among the adolescent population of WV and promote risk resiliency and strengthen youths personal assets. //2010//

Formal work with the Adolescent Health Initiative (AHI) began in 1988. Introduction of the developmental asset principles of Search Institute brought about a change in the mission in 1993. Search Institute has identified 40 positive experiences and qualities everyone can bring into the lives of youth, called the developmental assets. Organized training opportunities are provided by a workforce hired from the community they serve and offered in the community that the youth live. This workforce, called Adolescent Health Coordinators, is located in each of the eight regions of the state. These Coordinators offer young people, parents, and other significant adults in a child's life skill building sessions on conflict resolution, communication, increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improve responsible decision making.

The West Virginia Abstinence Education Project (AEP):
/2010/ Since the inception of the federal abstinence education funding, West Virginia has been at the forefront of administering these grant dollars by providing long-term, intensive programs in an asset development framework in public schools and community organizations. Abstinence education is primary health prevention that teaches youth the physical, emotional, social, intellectual, spiritual and financial benefits of abstaining from sexual activity. Abstinence Only Education funds have been discontinued by Congress. //2010//

EPSDT/HealthCheck:
The OMCFH administers the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for EPSDT members not enrolled in a health maintenance organization (HMO) statewide, for all children receiving Physician Assurred Access Services (PAAS) and children receiving SSI. The program is administered under an OMCFH contract with the State's Medicaid agency, Bureau for Medical Services. OMCFH has provided EPSDT administration for 30 years.

EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exam even if the service is not a part of the Medicaid State Plan.

EPSDT services include: 1) one or more physical exams each year based upon an age dependent periodicity schedule; 2) dental services; 3) vision services; 4) immunizations; 5) hearing services; 6) laboratory tests; 7) treatment for any health problems discovered during the exams; 8) referrals to other medical specialists for treatment; 9) monitoring the child's growth and development; 10) follow-up check-ups; 11) health education and guidance; and 12) documentation of medical history.

EPSDT, known as HealthCheck in West Virginia, has an outreach component responsible for meeting federal EPSDT informing, exam scheduling assistance, and follow-up requirements. Pediatric Program Specialists are assigned by region to accomplish outreach activities for EPSDT members. The Pediatric Program Specialists are responsible for provider training and on-going technical assistance. Paraprofessionals known as Family Outreach Workers provide outreach and informing services to those children not enrolled in managed care.

/2009/ On July 6, 2007, 143,534 children were approved for Medicaid. Because Medicaid has mandated HMO enrollment, some counties are now completely served by HMOs. Of the 143,534 children enrolled in Medicaid, 115,150 are with an HMO, and 28,384 are currently assigned to the OMCFH for management. Of the 28,384 managed by the OMCFH 10,716 are SSI, 13,928 are in a Physician Assurred Access Service and 3,740 are fee-for-service Medicaid.

During FY 2007, (10/1/06 - 9/30/07), the number of Outreach Workers assigned to manage Medicaid child beneficiaries not enrolled in an HMO was reduced from 25 to 19. Attrition of Outreach Worker positions will continue until the number is down to 9 //2009//. ***/2010/ Currently there are 7 Outreach Workers and 2 Foster Care Liaisons. //2010//***

Children's Dentistry Project:
/2010/ This Project works in concert with other Office of Maternal, Child and Family Health programs, Head Start and the public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services through educational instruction. Oral health efforts are funded from Title V and State appropriation. The Program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children and adolescents which encourage behavioral change; i.e., regular check-ups, brushing/flossing and use of mouth guards during sports activities. OMCFH has contracts with local health departments, primary care facilities and oral health care professionals to provide educational services and materials to all 55 counties in West Virginia. These local health departments and contracted dental hygienists are responsible for oral health education efforts that include working with the public school system. The Office has developed education modules approved by the WV Dental Association, and utilizes oral health supplies and education materials that are used in public school instruction. This Program also supports fluoridation and sealant efforts in the community, in addition to providing oral health supplies and education materials requested by various partners throughout the state. //2010//

Children With Special Health Care Needs:
/2010/ The Children with Special Health Care Needs (CSHCN) program is housed within the Division of Infant, Child and Adolescent Health. CSHCN has a strong care coordination component, providing care coordination services to children, age birth to 21, who have a variety of health care payers such as WV Medicaid, CHIP, PEIA, Blue Cross Blue Shield, Title V and other forms of insurance. The program is structured to be community based and family-centered. CSHCN clinics are established statewide, as well as in collaboration with some of the tertiary care centers, to provide services as close to family residence as possible. In addition to contracted specialty physicians, clinics are also staffed by nurses, social workers and support staff who work as a multi-disciplinary team to provide health care management services and psycho-social support. These services include: assistance with obtaining Durable Medical Equipment; development of individualized care plans and assessments; arrangements for follow-up care; assessment of daily living skills; assistance with transportation and assistance with transitioning to adult living and workforce entry. //2010// The OMCFH continues to work diligently with members of the SSI/OMCFH Task Force to formalize outreach and agency linkages to achieve awareness/knowledge of who and how programs can be accessed. While this cooperative agreement encompasses all children with disabilities, our initial efforts in 1996 targeted low birthweight babies and early intervention eligible children (birth to three years of age). More recently, the Task Force began efforts to ensure that children with disabilities who are within transitional age groups (specifically, three to six years and 16 to 21 years) receive prompt, appropriate services to enable a smooth transition to school and/or the workplace. Through a cooperative agreement dating back more than twenty years between the Office of Maternal, Child and Family Health and Bureau for Medical Services-Medicaid, Children with Special Health Care Needs staff provide care management services to Title XIX sponsored children, which maximizes

Title V monies for non-insured and/or underinsured, medically indigent children.

Parent Network Specialists System:
In conjunction with the West Virginia University Center for Excellence in Disabilities (WVUCED), Title V funds the Parent Network Specialists system. Five parents of developmentally disabled children serve an assigned regional area of West Virginia linking families to resources, information and community services.

Long-term student trainees at the Center for Excellence in Disabilities (CED), funded by the Maternal and Child Health Leadership Education in Neurodevelopmental Disabilities (LEND) grant are currently attending and participating in a variety of clinics at the Health Sciences Center including the CED's own Feeding and Swallowing and LEND Clinics. In addition to their grant-related activities, students attend Professional Development Seminars, the most recent one being Ethics and Disability.

The Interdisciplinary Certificate Program in the Field of Disability Studies has seen consistent and significant growth over the past year. Their academic disciplines include speech pathology, physical education/teacher education, nursing, child development and family studies, psychology, physical education/kinesiology, athletic coaching education, exercise physiology, engineering, occupational therapy, special education, early childhood education and family and consumer sciences. In addition, a student was awarded a CED Research Stipend to produce a training workshop for obstetric nurses who are working with new mothers who have disabilities. This was a collaborative effort among the CED, the Center for Women's Studies at WVU and the WVU School of Nursing.

In an effort to infuse information about disability into the curriculum at the West Virginia University School of Medicine, the CED presented a workshop with 4 concurrent sessions, through which medical students rotated. Students experienced a variety of disciplines and work on problem-solving case studies involving patients with disabilities. Faculty and staff from the CED facilitated the sessions and were available to offer suggestions and answer questions.

Systems Point of Entry:
Systems Point of Entry serves as the centralized information, patient education distribution and referral center for the Office of Maternal, Child and Family Health. SPE is responsible for the intake and eligibility review for the Children with Special Health Care Needs (CSHCN) program. SPE also does eligibility review for the Right From the Start (RFTS) program for West Virginia residents who have been denied services through Medicaid for their pregnancy. Systems Point of Entry is very unique in that whenever any type of contact is made, whether, by phone on one of OMCFH two toll-free lines, email, or applying for one of the various programs, SPE focuses on the overall needs of the client/family, making community referrals whenever appropriate.

Toll-Free Lines: ***/2010/ Referral Information Network (RIN)***
Systems Point of Entry is responsible for the two phone numbers and four toll-free lines located in OMCFH. West Virginia callers are responded to Monday through Friday, except holidays 8:30-5:00, by either a licensed social worker or a registered nurse. The two toll-free Responders provide referrals and information to all of West Virginia statewide free of charge. In calendar year 2006 the two toll-free lines received 24,880 calls. In 2007 there were 22,795 calls and in 2008 there were 14,822 calls recieved on the toll-free lines. //2010//

WV Birth to Three/Part C IDEA:
Provides therapeutic and educational services for children age 0-3 years and their families who have established, diagnosed developmental delays, or are at risk of delay /2009/ through a network of credentialed practitioners statewide. //2009// The goal is to prevent disabilities, lessen effects of existing impairments, and improve developmental outcomes. Services are provided based on individual child/family assessments and delivered by community-based practitioners who are credentialed by Birth to Three. The service system is supported by Title V, Part C, state

appropriation and Title XIX.

Genetics Project:
This project provides clinical genetic services preconceptually and for children with congenital defects at six satellite locations under the auspices of WVU, Department of Pediatrics. Services include diagnosis, counseling and management of genetically determined disease, prenatal diagnosis and counseling, and evaluation of teratogen exposure. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community caring for children with metabolic disease. With the expansion of newborn screening for metabolic diseases to meet the national standards, the Genetics Project has had to expand as well. WV only has one Geneticist and the WVU Department of Pediatrics is recruiting for additional physician positions. In order to meet current service demand, WVU has expanded the number of genetic counselors using OMCFH resources to support their salaries.

/2010/ Division of Research, Evaluation and Planning:
This Division is responsible for the epidemiological and other research activities of the Office of Maternal, Child and Family Health, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the Office of Maternal, Child and Family Health's planning efforts are data-driven. All of the Office of Maternal, Child and Family Health's program specific databases are housed in this Division, and are linked with program leadership to assure consistent visioning.

The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project, and the Childhood Lead Poisoning Prevention Project (CLPPP), sponsored by the Centers for Disease Control and Prevention (CDC); the Sudden Infant Death Syndrome (SIDS) Project mandated by State Statute but financed by Title V; birth defects surveillance and in conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project, now supported by State funds and revenue generation, and Newborn Hearing Screening, supported by insurance and HRSA. This Division is responsible for SSDI data integration activities and the Title V Block Grant application. The Division is also responsible for development of data applications and data analysis for OMCFH programs and projects. //2010//

Pregnancy Risk Assessment Monitoring System (PRAMS):
This is a population-based surveillance system of maternal behaviors and experiences before, during, and in the early infancy of the child. The Project is an integral component of the Office. Data and information gathered by the Project are used by the West Virginia Bureau for Public Health as a resource for both the development of maternal, child and family health programs and for evaluating the new and existing programs and projects. Some of the data gathered includes smoking during pregnancy, intendedness of pregnancy, entry into prenatal care, etc.

Sudden Unexplained Infant Death Syndrome (SUIDS):
This project collects and reports data regarding the occurrence of SUIDS deaths in the State. When a SUIDS death is reported, a local health department nurse is contacted to make a home visit to interview and assess the needs of the parents. Educational and grief information is sent to the family upon request. Training is provided to emergency room personnel, police, and funeral home personnel to sensitize them and offer strategies for responding to families. The Project Coordinator, as well as, the OMCFH Director are members of the Child Fatality Review Team. ***/2010/ On average there are 35 infant deaths per year attributed to SUID. There has been discussion to organize a fetal and infant mortality review team, but past experience with this effort has not proven to be successful. //2010//***

Newborn Metabolic Screening:
/2009/ Expansion of newborn screening testing to include the 29 nationally recommended tests was mandated by the 2007 Legislature. Newborn screening rules were passed during the 2008 Legislative session mandating insurance companies to pay for system costs. ***/2010/ In February***

2009 WV began screening for all 29 of the nationally recommended disorders using the State Laboratory. //2010// //2009// Follow-up is provided by state office nursing personnel, in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCFH. Title V state office nurses and administrative personnel track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family.

Newborn Hearing Screen:
The Newborn Hearing Screening (NHS) Project ensures that all children born in WV are screened at birth for the detection of hearing loss. Case management services are provided by the RFTS Program for every infant who either fails the hearing screen or is not screened prior to hospital discharge. The NHS Project has adopted goals set forth by Healthy People 2010 and the Centers for Disease Control and Prevention who recommend that all newborns be screened for hearing loss prior to one month of age, have an audiological evaluation by three months of age, and if needed, have appropriate intervention services by six months of age. Children in need of intervention are referred to Children with Special Health Care Needs and WV Birth to Three. Referrals are also made to the Ski*Hi Parent/Child Program for home-based family education and support for deaf and hard of hearing children and their families, administered by the WV School for Deaf and Blind.

Childhood Lead Poisoning Prevention Project (CLPPP):
This project is a collaborative effort between two Offices in the Bureau for Public Health, OMCFH and the Office of Environmental Health, funded by the CDC. An Advisory guides the operation of the Program, assisting the State with determining the extent of childhood lead poisoning in WV. To this end, extensive data gathering and analysis are routinely distributed. The Office of Environmental Health Services provides assessment of home and environment for residences of children with elevated blood lead levels. The OMCFH's CLPPP nurse case manages all children with a positive blood lead level of greater than or equal to 10mcg.

Birth Defects Surveillance System:
Tracks the incidence of specific diagnostic codes using the birth files, death files and hospital charts of the infant as well as the mothers. All infants identified with a birth defect are referred to CSHCN for services and referrals. A CDC grant funded active case ascertainment in 2004 and 2005, but loss of that funding meant the closure of actively obtaining information from the medical record. Birthing facilities now send in monthly reports listing the diagnostic codes obtained at birth. Data is then entered into the surveillance system.

Quality Assurance/Monitoring Unit:
The OMCFH Quality Assurance/Monitoring Team has over 25 years proven experience in conducting on-site clinical review. These reviews occur with every medical and educational provider who contracts with the Office - private physicians, primary care centers, local health departments, hospitals, etc. The reviews are conducted on site and include patient interviews, chart reviews, and provider interviews. Formal reports are submitted to each program. Technical assistance and corrective action plans are the next step in the process

C. Organizational Structure

/2010/ West Virginia's Office of Maternal, Child and Family Health is located within the State's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources. The Bureau's overall goal is to attain and maintain a healthier West Virginia. Housed within the Bureau for Public Health are the following Offices, Centers and Advisors: Office of Maternal, Child and Family Health, Office of Community Health Systems and Health Promotion, Office of Environmental Health Services, Center for Statistics and Vital Records, Office of Chief Medical Examiner,

Office of Health Facility Licensure and Certification, Office of Laboratory Services, Office of State Trauma and Emergency Care System, Office of Surveillance and Disease Control, Center for Threat Preparedness, Office of Nutrition Services (WIC) and Public Health Advisors for: Workforce Development, Information Technology, Minority Health and Health Disparities and School Health. Please see attached organization chart. //2010//

The Office of Maternal, Child and Family Health provides operational guidance and support to providers throughout West Virginia to improve the health of families. In addition to providing funding support for actual service delivery, the Office of Maternal, Child and Family Health funds projects intended to develop new knowledge that will ultimately improve the service delivery of the health community.

/2009/ It is important to remember that improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for 30 years to make a difference in the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and under insured women and children.

Nationally, federal health agencies, insurance providers, health researchers, and policy groups are promoting the need for "Continuum of Care" with patients. It is recognized that continuity of coordinated, quality care is the best model of care for patients and is the most cost effective method for providing and paying for services. Continuum of care is best achieved through consistent access to quality health providers and services. Gaps in consistent care result in increased need for intensive and crisis care, which leads to higher costs for health care services. Research supports greater patient compliance with care plans when a positive relationship with their health care provider is well established. The Right From The Start (RFTS) Project has an established network of Registered Nurses and Licensed Social Workers who have provided this model of care since the 1980s.

Ensuring access to health care for low-income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and the Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at-risk of adverse health outcomes. This partnership has not only expanded the State's capacity to finance health care for medically indigent women and children, but has also strengthened the delivery of care by establishing service protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well-being.

West Virginia Medicaid and the OMCFH share a common commitment to the goal of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. These agencies also recognize the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding for targeted populations, targeted outreach, risk reduction education, and development of comprehensive programs that address both medical and behavioral issues. //2009//

/2010/ The Office of Maternal, Child and Family Health is comprised of multiple divisions, programs, and projects, all designed to promote improved health across the life span. //2010//

/2010/ Updated organization charts for both the WV Bureau for Public Health and the Office of Maternal, Child and Family Health are attached. //2010//

An attachment is included in this section.

D. Other MCH Capacity

/2010/ As of April 2009, there are 160 staff positions in West Virginia's Title V agency, the Office of Maternal, Child and Family Health, which consists of: 7 senior management, 69 professionals, 30 medical professionals, 48 clerical, and 6 technicians. //2010//

/2010/ Direct health services and education are provided through the network of community-based entities including private practitioners, school-based health centers, local health departments and independently enrolled practitioners that include: occupational therapy; physical therapy; speech pathology; developmental specialists, etc. //2010//

During Fiscal Years 1997 and 1998, two parent advisors were recruited by the Office of Maternal, Child and Family Health, one as a paid employee and the other as a volunteer. Since that time these positions have been maintained and increased to a total of five paid parent advisors called Parent Network Specialists (PNSs). The CSHCN Program has continued funding the PNS system which is administered by the West Virginia University Center for Excellence in Disabilities (WVUCED). The PNSs are parents of children with disabilities who are located in communities throughout the State. The State is divided into five (5) regions and each PNS is assigned a specific region of responsibility. The PNS also has responsibility to supply resource information and Care Notebooks to each CSHCN participant. The Care Notebooks were developed as a casemanagement tool so that parents could track appointments, medicines and treatments.

/2009/ Beginning in July 2007, the Parent Network embarked on two new efforts: transition services for young adults and the development of parent support groups. The PNS have participated in community health fairs and shared medical and educational transition information with adolescents and young adults. Additionally, they sought the assistance of a licensed counselor to teach them how to organize parent support groups. Both of these efforts will continue through the next contract year. The Parent Network Specialists also have the responsibility of supplying resource information and Care Notebooks to each CSHCN participant. The Care Notebooks were developed as a case management tool so that parents could track appointments, medicines and treatments. //2009//

/2009/ The West Virginia Developmental Disabilities Council ran an ad in the Charleston, WV newspapers on June 16, 2008 soliciting applications from adults with developmental disabilities and parents of young children with developmental disabilities to participate in the Partners in Policymaking series. The Council stated they were seeking highly motivated men and women who represent different ethnic backgrounds , different geographic regions of the state and a variety of developmental disabilities. The Partners in Policymaking is a leadership training program for self-advocates and parents. Partners learn about current issues and state-of-the-art practices. They also become familiar with the policymaking and legislative processes at the local, state and federal levels. The program teaches competencies necessary for individuals to become advocates who can influence the system of services for people with developmental and other disabilities. Partners attend two-day training sessions eight times a year, from September through May. The program covers the cost of lodging, meals and travel. Additionally, stipends are available for respite care services or personal assistance services. //2009//

/2010/ Also available to WV residents is the Tiger Morton Catastrophic Medical fund. This fund assists persons with medical expenses who have had a catastrophic medical incident and either are underinsured or uninsured. Referrals to this fund are managed by the Systems Point of Entry staff within OMCFH. //2010//

/2010/ The Parent Network Specialists, in collaboration with the West Virginia University School of Dentistry, conducted surveys to access dental services for children with special

health care needs and evaluate service availability from the parent's perspective. Six hundred and fifty (650) surveys were sent to parents in 30 West Virginia counties. One hundred eighty-three (183) or 28% were completed and returned. The survey objectives were:
a. To determine the knowledge base that parents of children with special health care needs have about dental care.
b. To determine the most common problems parents of children with special health care needs face when trying to find a dentist.
c. To determine if parents of children with special health care needs feel their child is receiving adequate dental care and what improvements are needed.

The study concludes that 65% of parents of children with special health care needs felt their child's needs are being met and that the majority of parents have been educated about preventive dental care for their children. To overcome obstacles, dental health care professionals will need to continue to expand their knowledge about treatment of patients with special needs which is a curriculum component of the WV School of Dentistry and an on-going educational issue among the WVDental Association. //2010//

/2010/ Meeting the health and psychosocial needs of persons with developmental disabilities are reflected in part as: WV Special Olympics sponsor Camp Tommy, a day camp held annually for the developmentally and physically disabled. The camp is held in the Buckhannon-Upshur High School and is held the third week in July. Approximately 100 campers of all ages participate. A variety of planned programs as well as crafts, sports, games and socialization is provided. The camp received a contribution of $5000 from the OMCFH. //2010//

/2010/ The CSHCN Program, through the Office of Maternal, Child and Family Health, supports the Mountaineer Spina Bifida Camp held in June for those children up to age 21 with the diagnosis of Spina Bifida or Myelodysplasia. In 2008, the camp celebrated its 23rd year of residential camping where children learn independent self care skills while participating in crafts, fishing, swimming, games, talent shows and a "prom" night. The CSHCN Program provides financial support for transporting equipment and supplies to staff who volunteer as counselors. //2010//

Other topics of capacity interest include:

/2010/ The WV OMCFH has applied for and received the State Systems Development Initiative Grant from HRSA for many years. This Grant has allowed us to increase our data collection and analysis capacity over the years. The SSDI Project is housed within the Division of Research, Evaluation and Planning. The Division has developed a Data Mart that has access to data from all of OMCFH's programs as well as birth records, infant death records and Medicaid eligibility files. This enables the OMCFH to examine and analyze data using multiple data sources. //2010//

The Right From the Start Program's data collection system went web-based in May, 2007. Previously there were eight Regional centers who collected data on eight stand alone computers. Not only did we have user and computer problems across the State, but the data was not always complete. It was difficult to report accurate information. The web-based data collection not only saves traveling time to the different sites, but provides more accurate data.

/2010/ The Division of Research, Evaluation and Planning has access to multiple data sets to be able to match data to evaluate program activities and results that fall under the OMCFH umbrella. These data bases include: birth and infant death files, newborn hearing screening, newborn metabolic screening, childhood lead screening, birth defects, SIDS/SUID, PRAMS, Birth Score (newborn high risk assessment screening), Medicaid eligibility files, FACTS (Families and Children Tracking System), Family Planning, Right

From The Start, Early Intervention/Part C and CSHCN. //2010//

/2010/ During FY2009, the West Virginia Abstinence Education Project (AEP):
•Expanded the AEP's services to include an additional four counties not previously served with no additional funding;
•Provided full curriculum classes (at least five hours of instruction) to 8,732 students in nineteen West Virginia counties;
•Worked with community partners to coordinate four regional Teen Expo events across the state;
•Actively promoted the National Campaign to Prevent Teen Pregnancy's National Day event as part of National Teen Pregnancy Prevention Month. The AEP distributed National Day items to students attending curriculum classes as well as high school proms and athletic events;
•Coordinated Mother-Daughter Retreats and Father-Daughter Date Night events throughout the northern panhandle of West Virginia;
•In partnership with the Healthy Families Initiative, hosted a marriage/relationship conference titled Laugh Out Loud at North Bend State Park;
•Coordinated a prom gown auction event in Wood County, WV. High school girls were provided with educational presentation and literature during the event. New and gently used prom gowns were donated by area stores and private donors. The gowns were sold at the auction between $10 and $25, allowing girls to buy gowns they otherwise could not afford;
•Released radio and television PSA's as part of the national Parents Speak Up! campaign made available by the Administration for Children and Families (ACF);
•Displayed educational literature at more than 70 events across the state;
•The CHAT (Communities Hearing Abstinence Truth) drama team (consists of nine teens) did three "human videos" that included discussions at a Teen Institute event;
•Featured speaker Keith Deltano at several Marion County schools. Keith also provided parent and youth workshops. Approximately 3,500 parents and students attended the events;
•Provided marriage and relationship education services featuring the PREP (Prevention and Relationship Enhancement Program) curriculum in north central West Virginia;
•Partnered with Mission WV in the application for Community Based Abstinence Education (CBAE) funding available through the ACF, a different federal funding source than AEP. This five-year grant award provides funding to an additional ten counties serving approximately 4,000 youth and continues pending future federal funding;
•Last year, the AEP served more than 11,000 students, parents, community members.

The Adolescent Health Initiative:
•Presented Healthy Family Relationships to Marshall County Mother & Daughter Program
•Partnered with the Global AIDS Task Force Team and United Methodist Ministries to host a United Methodist conference.
•Participated in a briefing for key stakeholders hosted by Advocates for Youth and the WV Emergency Contraception Initiative in Morgantown.
•Developed posters and banners to provide health information to the community and raise awareness about available health resources.
•Conducted a Family Life Expo in Preston County;
•Hosted the 19th Annual Region VIII Conference entitled "Reviving the Art of Serious Conversation between Parents and Kids."
•Sponsored a teen retreat entitled Peace, Love Rock and Soul;
•Presented the teen dating violence play, "Love is not Abuse" in partnership with the Contemporary Youth Arts Company;
•Partnered with the Raleigh County Family Violence Task Force in the application of a Violence Against Women Act grant of $67,354.
•Offered several presentation workshops across the state to include: Relational Aggression; Helping Youth Thrive: The Power of Developmental Assets; Bringing Forth

the Positive Potential of Youth and A Powerful Tool For Positive Change; The Developmental Assets Model & Your Family. //2010//

Brief biographical sketches of the Office Director and the Division Leaders are outlined below:

Patricia Moore-Moss, MSW, LCSW--Director Office of Maternal, Child, and Family Health
EDUCATION:

West Virginia University; School of Social Work, 1976 - M.S.W.
West Virginia State College, 1973 - B.A. Sociology - Social Work
M.S.W./L.C.S.W. - License No. CP00208394

PROFESSIONAL EXPERIENCE:

Director of the Office of Maternal, Child and Family Health (4/92 to Present)
Bureau for Public Health
Office of Maternal, Child, and Family Health
Social Service Consultant - Charleston Area Medical Center (1990 - 1992)
Bureau Administrator Social Services (9/88 - 11/89)
Assistant Director (1988 - 1989)
West Virginia Department of Health
Division of Maternal and Child Health
Executive Assistant to the Director (1986 - 1988)
Maternity Services Program Director (1980 - 1986)
Social Worker/Patient Educator (1/79 - 6/80)
West Virginia Department of Health
Improved Pregnancy Outcome Project
Assistant Director of Social Services (8/76 - 12/78)
Charleston Housing Authority

Kathryn G. Cummons, MSW, ACSW--Director, Division of Research, Evaluation, and Planning
EDUCATION:

Master's of Social Work, West Virginia University, Morgantown, WV (1988)
Bachelor's of Social Work, West Virginia University, Morgantown, WV (1974)
Minors in Psychology and Speech
Attendance at a variety of training and educational seminars on a wide array of topics throughout the past 28 years related to employment at the time.

PROFESSIONAL EXPERIENCE:

Director, Research, Evaluation, and Planning (9/2000 - Present)
Bureau for Public Health
Office of Maternal, Child, and Family Health
Clinical Social Worker, (12/99 - 9/2000)
Comprehensive Psychological Services
Clinical Social Worker, (9/89 - 7/90) and (5/98 - 12/99)
Charleston Area Medical Center
Director of Social Work Services and Discharge Planning (8/90 - 5/98)
Charleston Area Medical Center
Administrator (7/84 - 5/89)
Northern Tier Youth Services
Supervisor, (6/81 - 7/84)
Lutheran Youth, and Family Services

/2010/ Christina Mullins, M.A. Director, Division of Infant, Child and Adolescent Health

(including CSHCN)
EDUCATION:

Psychology, MA, Marshall University, 1997
Psychology, BA, Marshall University, 1995

PROFESSIONAL:

Director, Division of Infant Child and Adolescent Health, Bureau for Public Health (2/09 -- Present)
Program Director, Breast and Cervical Cancer Screening Program, Bureau for Public Health (2004 - 2009)
Associate Division Director, Division of Tobacco Prevention, Bureau for Public (2002 -- 2004)
Associate Program Director, Tobacco Prevention Program, Bureau for Public Health (2000 -- 2002)
Program Coordinator, Tobacco Prevention Program, Bureau for Public Health (2000)
Supervised Psychologist, Allied Behavioral Services (1997 -- 2000)
Teaching Assistant, Psychology Department, Marshall University (1996 -- 1997) //2010//

Anne Amick Williams, RN, BSN, MS-HCA -- Director, Division of Perinatal and Women's Health
EDUCATION:

West Virginia University School of Nursing, Bachelor of Science in Nursing, 1982-1986
Graduated Magna Cum Laude
Marshall University Graduate College, Master of Science in Management/Healthcare Administration, 1993-1999

PROFESSIONAL EXPERIENCE:

Director, Division of Perinatal and Women's Health (1/06 to Present)
Office of Maternal Child and Family Health
Bureau for Public Health

Director, Family Planning Program (1991 to 1/06)
Office of Maternal Child and Family Health
Bureau for Public Health

Clinical Nurse I -- Neonatal Intensive Care (1988 to 1991)
Charleston Area Medical Center -- Women's and Children's Hospital

Clinical Nurse I -- Pediatrics Unit (1986 to 1988)
Charleston Area Medical Center -- Women's and Children's Hospital

E. State Agency Coordination

The Office of Maternal, Child and Family Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements with community agencies for services offered through the Right From The Start Perinatal Program, Family Planning and Children with Special Health Care Needs. The Office of Maternal, Child and Family Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation 42 CFR sub-section 431.615 (C)(4). The Office of Maternal, Child and Family Health has

administrative responsibility for dental and vision care for persons moving from Welfare to Work. These efforts are financed by TANF resources; a copy of the grant agreement may be obtained from the OMCFH. As a component of the Birth to Three/Part C system change initiative, an additional interagency agreement has been finalized with the Bureau for Medical Services, utilizing the unique statutory relationship between Title XIX and Title V, the agreement established the Office of Maternal, Child and Family Health as the sole provider of early intervention services. The Department of Health and Human Resources has contracted with a private agency to serve as a central finance office to coordinate all funding sources for early intervention services, a centralized data system, and claims. This was let as a request for bid and is administered outside of state government.

The Office of Maternal, Child and Family Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include birth score (administered by WVU), birth defect registry, pregnancy tracking systems, newborn metabolic screening, childhood blood lead level screening, and newborn hearing screening. In addition, because we administer the EPSDT Program, children who have conditions that may be debilitating and/or chronic diseases, are referred to the CSHCN Program for further evaluation. This connection with EPSDT, which targets some 200,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. OMCFH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established in 1980, average over 1,000 calls per month. Each caller receives individualized follow-up from our Systems Point of Entry staff to assure referrals and pertinent information related to the request met their need. OMCFH toll free lines always receive accolades. Evaluation materials are on file and available if desired.

RISK REDUCTION THROUGH FOCUS ON FAMILY WELL-BEING (HAPI) PROJECT

/2010/ The OMCFH and West Virginia University (WVU) finalized an Agreement for joint implementation of the Risk Reduction Through Focus on Family Well-Being/Helping Appalachian Parents and Infants (HAPI) Project, a Healthy Start grant, in RFTS Region VII. Several providers including mental health providers and dentists signed agreements to participate in the program to provide patient services. The services encompass care coordination services provided to pregnant women and infants, including a preconception phase, as per the existing RFTS Project. The HAPI Project focuses on helping women become healthier before becoming pregnant, encourages spacing of pregnancies, provides child care services, oral health care reimbursement, transportation assistance to doctor appointments and payment for mental health services. Curriculum for patient education was developed by WVU. OMCFH, as the subcontractor, acts as the fiscal agent for HAPI. Billing procedures have been developed by OMCFH and patient services invoices are processed by the State on behalf of the grantee, WVU.

The OMCFH and WVU continue to collaborate to provide services to high-risk pregnant women and infants through the Healthy Start, HAPI Project. Initially started in four (4) West Virginia counties, the HAPI Project has expanded to include eight (8) counties, with service components in areas of: oral health services; substance abuse screening and referral; and outreach services utilizing former consumers.

The long-term goal of the project is to decrease the incidence of low birth weight infants born in West Virginia by reducing recurrent low birth weight. It is our hope that resulting data may also show that there is a significant benefit of cost savings through the risk reduction plan for at risk families. Hopefully from this data, RFTS can justify the benefit in expanding the current case management program to include the risk reduction plan for families and allow implementation of a longer period of eligibility for case management to assist at-risk families. //2010//

PRENATAL RISK SCREENING

/2010/ Concerns about maternal and infant health were the catalysts for convening the WV Perinatal Partnership in 2006. The resulting "Blueprint to Improve West Virginia Perinatal Health," contained multiple recommendations and action steps to make needed system improvements.

Policy recommendation number one was to create a coordinated statewide perinatal system including the request that the state identify a maternal risk scoring instrument to be used universally by all obstetrical medical providers and all payers.

Comprehensive risk screening enables the prenatal care provider to determine whether the woman, the fetus, or the infant are at increased risk and provides the basis for further assessment and intervention. Risk factors are characteristics that indicate a higher probability of adverse outcome and help guide the action by the woman, social supports, and the medical provider.

The Universal Risk Screening Committee believes that early prenatal care, with an emphasis on risk screening at the first prenatal visit and appropriate follow-up, is critical. In WV, the most likely adverse pregnancy outcome is preterm labor and/or low birthweight. A review of health data and key informant survey responses confirms that smoking during pregnancy plays a huge role in poor pregnancy outcomes. In WV, 27.2% of pregnant women smoke compared to the national average of 12.7%.

Since the 1980s, West Virginia has screened low income, government-sponsored women for adverse outcomes, and although the screening instrument has changed numerous times over the last 25 years, the use of the information to prevent or treat conditions associated with poor pregnancy outcomes has remained the same. Currently, low income pregnant women who receive government-sponsored health care are routinely screened using the Prenatal Risk Screening Instrument (PRSI), developed by WVU, Department of Ob/Gyn. The risk scoring forms completed by the pregnant woman's medical practitioner trigger a referral to the RFTS Project. The RFTS provider network are community-based licensed social workers and nurses who provide individual care planning, taking into account medical and psychosocial patient risks. The RFTS workforce has responsibility to arrange for community resource referral and consultation, as well as offering in-home educational services designed to affect patient behavior. The challenge is, while the screening has enjoyed widespread use, it is not used for pregnant women who have commercial coverage, and even if the PRSI were completed, a pregnant woman who is not in government-sponsored care is not eligible to receive the in-home care coordination offered by the RFTS network. Further, participation in RFTS, in its current iteration, is strictly voluntary, although all pregnant Medicaid beneficiaries and Title V beneficiaries are eligible for the program.

While other insurers do support prenatal risk screening for their beneficiaries, the intensity and the type of management offered in response to the probability of adverse patient outcome varies by carrier. There is no insurer that provides the care management equivalent of RFTS, i.e., home visits and one-on-one education.

A survey of West Virginia medical obstetrical practitioners was completed by OMCFH to determine their current risk screening practices including the instrument used and the PRSI was most often cited as the tool used. Out of 120 surveys returned, 40% reported regular use of the PRSI, 14% used an ACOG tool, 4% used the POPRAS, 14% used an in-house tool and 28% were not using a risk assessment form. The PRSI includes both medical history and psychosocial information to assess risk. Screening differs from assessment in that screening only identifies those most likely to be at increased risk and should result in further assessment to determine intervention and service need. In short,

risk screening is the beginning of the process.

The Universal Prenatal Screening Committee recommended (1) the PRSI, a screening instrument unique to West Virginia and not copyrighted, can be used statewide without significant cost investment; (2) the PRSI is one page and not burdensome for the medical practitioner or other office staff; (3) the PRSI, as evidenced by the survey, already enjoys widespread acceptance and use; (4) because the form is homegrown, there is the option to modify it; (5) modifications to the form can, in time, be a result of data gathering, analysis and evaluation to better reflect West Virginia's need and patient risks.

Legislation passed during the 2009 session as Senate Bill 307, creating the Maternal Screening Act, relating to development of a maternal risk assessment advisory council; providing for legislative findings; setting forth responsibilities of the advisory council; providing for legislative rule-making authority within the Department of Health and Human Resources to develop a uniform maternal risk screening tool; providing for applicability of the screening tool once developed; and providing confidentiality of the tool.

The bill states the "Legislature finds that there is a need for a more comprehensive and uniform approach to any screening conducted by physicians and midwives to discover at-risk and high-risk pregnancies. A uniform approach would simplify the process, standardize the procedure and better identify those pregnancies that need more in-depth care and monitoring. Additionally, a uniform application would provide better and more measurable data regarding at-risk and high-risk pregnancies. This would allow public health officials to gain a better understanding of those conditions that are most frequently observed and to develop methodology to address those concerns." The bill establishes an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to provide the Office with assistance in the development of a uniform maternal risk screening tool. Once developed, all health care providers offering maternity services would be required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral. //2010//

West Virginia's Office of Maternal, Child and Family Health is known for its positive partnerships with the medical community, the University Affiliated Programs, the State Department of Education, and the March of Dimes Chapter, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects. Another initiative made possible was the Richard Windsor smoking cessation program in partnership with the Office of Epidemiology and Health Promotion, who contributed tobacco funds for the purchase of CO monitors for the 233 care coordinators for use with pregnant women statewide. /2009/ A recent initiative is kindergarten screening using the EPSDT (HealthCheck) protocol, called Kids First. The objectives of the initiative are: to establish a medical home for the child, to allow school systems to focus on providing needed services for children with identified deficits, to assist families in finding treatment resources, and to promote healthy lifestyle activities. The focus of the screening will be on the domains of oral health, vision, hearing, speech and language, and behavior/development. Kids First is an example of high-level collaboration in government. Three Cabinet level agencies, the Department of Education, the Department of Health and Human Resources and the Department of Administration, are working closely together to bring this project to the families of West Virginia. All insurers agreed to pay for the services. //2009// Another initiative is the West Virginia Perinatal Wellness Partnership that includes stakeholders from all across the State. Stakeholders include obstetrical and neonatal physicians, Medicaid, private insurance providers, OMCFH, Vital Statistics staff, the Hospital Association and the March of Dimes to mention a few. The 2007 work plan of the the Partnership includes the following: 1. Establish a statewide perinatal transport system, 2. Identify and address obstetrical provider shortage areas, 3. Address the lack of oral health care in pregnancy, 4. Identify costly medical procedures associated with

poor birth outcomes, 5. Develop an approach to identifying and treating drug use during pregnancy, 6. Promote perinatal worksite wellness, and 7. Support and promote breastfeeding.

The Birth to Three/Part C Program partners with a multitude of agencies to assist with child find efforts and to ensure needed services are arranged. In 2008, some 5,600 infants and toddlers received BTT services. This number is reflective of 2000 additional infants over a 5 year period. The increase is reflective of interagency child find efforts on the state and regional level. WV Birth to Three has institutionalized a variety of strategies for the early identification of infants and toddlers with developmental delay or significant risk factors. WV Birth to Three's interagency agreements with Title V, CHIP, Bureau for Children and Families, Head Start, and Medicaid assist in the early identification and referral of potentially eligible children. West Virginia finds that coordination with primary health care providers and other community partners is important to assure that children potentially in need of early intervention services are identified as early as possible.

WV Birth to Three continues coordination with Title V/CSHCN, Newborn Hearing, and Right From The Start programs to assure that infants failing the newborn hearing screen receive diagnostics, and referral to Part C and Ski *Hi when hearing loss is confirmed. The Birth Score universal newborn screening, conducted on all children born in West Virginia, identifies infants who are born with conditions that may make them at risk for developmental delay. Referrals are made directly to the appropriate Birth to Three Regional Administrative Unit (RAU). Public awareness and child find activities are conducted collaboratively with interagency partners, including Part B preschool, Child Care and Head Start. Examples of this collaboration include the publication and distribution of a quarterly magazine, annual calendars, and developmental wheels to county schools, physicians, Family Resource Networks, medical clinics, early childhood providers, and higher education faculty. The publications include information about how to make a referral to Part C, Part B, Head Start and/or Child Care. The WV Birth to Three Public Information Coordinator has worked closely with WV CHIP to develop parent educational and child find materials, to be distributed collaboratively. The WV Birth to Three Public Information Coordinator has participated in faith based planning initiatives coordinated through WV CHIP to provide information about WV Birth to Three as a resource for families.

Child find strategies have also included coordination with the Right From The Start and HealthCheck Programs coordinated through the Office of Maternal, Child and Family Health. Local Right From The Start personnel who work directly with high risk mothers and infants are able to identify those children who may be in need of early intervention services. Program Specialists within the HealthCheck Program, in their work with physicians, are able to provide information about the criteria and requirements, and importance of identifying children who may be in need of early intervention services. /2009/ Recent policy direction by the AAP to its members encouraging early screening for developmental delays and subsequent referrel to Part C have also contributed to increases in the number of children served by the program.

WV Birth to Three staff have coordinated with the Bureau for Children and Families, Child Protective Services, in the development of procedures to assure the referral of children who have experienced substantiated abuse and/or neglect. Training is provided to WV Birth to Three service coordinators and practitioners related to the requirements and coordination with Child Protective Services and Foster Care, /2009/ as required by the Federal Child Abuse and Protection Act (CAPTA). The number of child referrals from this requirement have increased from 89 to 580 in FY 2007. //2009//

The Select Committee on Veterans met to discuss health care, mental health care and other services available to active military service persons as well as veterans. The Committee heard from two representatives of the West Virginia Council of Churches about a new project called "When Our Military Members Are Deployed: Supporting West Virginia Military Members and Their Families." This statewide project is being spearheaded by the Council of Churches in cooperation with the Claude Worthington Benedum Foundation. Their mission is to engage

community agencies and veterans into a process that will identify and establish "community support in areas of stress management, substance abuse prevention and treatment, children's needs, and financial counseling and financial support." A staff person from the OMCFH's Systems Point of Entry is serving on the Select Committee. A Summit of veterans, active service, government officials, faith based groups, employers and labor organizations was held June 11-12, 2007, in Charleston, WV, to assess the needs of veterans in the community, establish networking capabilities, and to mobilize support for the project.

/2009/ The prevalence of Autism Spectrum Disorder (ASD) is approximately 1 in every 100 American children. In an effort to secure more commitment to expanding access to services such as early identification, diagnosis, early intervention, family support, etc. in West Virginia, the Autism Training Center at Marshall University received a funding increase of 1 million dollars for FY 09, making a total appropriation of $2,075,739 per year from the West Virginia Legislature.

In addition, the State Legislature, in 2008, introduced a bill to require health insurers to provide full coverage of prevention, detection, diagnosis and treatment of Autism Spectrum Disorder. The legislation did not leave Committee, in spite of much public advocacy during Disability Awareness Day at the State Legislature. Obviously this legislation was of interest to OMCFH, since the early intervention, Part C Program called Birth to Three serves many toddlers with autism. //2009//

Agency Partners include: (list not all inclusive)
-400+ medical contracts with private physicians, community health centers, local health departments and hospital based clinics for the provision of EPSDT.
-Birth to Three/Part C provides grants to local entities to act as system point of entry for eligibles.
-Memorandum of Understanding with WIC and SSA for referrals as referenced earlier.
-Working agreement with the Office of Social Services (Title IVB) for children in state custody to receive enhanced health screens through OMCFH's medical provider networks.
-Working agreement with the Office of Social Services for interagency training for professionals and para-professionals serving young children-including use of assistive technology and understanding ADA.
-Agreements with WVU for genetic services and administration of the Birth Score Project.
-151 agreements statewide with private physicians, community health centers and local health departments for Title X family planning services.
-114 agreements serving 179 sites statewide for breast and cervical cancer screening program services.
-Agreements with 8 agencies to locally administer the Right From The Start Project and subsequent agreements with multiple agencies to provide direct services to perinatal populations who employ more than 165 licensed social workers and nurses, 83 Designated Care Coordination Agencies, 76 OB providers (contracted)
-March of Dimes
-Developmental Disabilities Council
-Medical Advisories for all programs and projects
-University Center for Excellence in Disabilities
-Interagency Coordinating Council for Birth to Three/PartC (state statute established).
-Department of Education/Healthy Schools
-Starting Point Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies
-Head Start
-Cancer Coalition (established state statute)
-Membership, West Virginia Association of Community Health Centers
-WV Commission for the Deaf and Hard of Hearing (Board Member)
-Women's Health Advisory Council
-Children's Mental Health Collaborative
-WVU Healthy Start HAPI Project
-American Lung Association
-WV Division of Tobacco Prevention

-All Offices within WV DHHR

/2009/ The West Virginia University School of Medicine has been recognized as one of the top ten schools of medicine in the country for rural medicine. WVU made the top ten list for the first time in U.S. News & World Report's 2009 edition of "America's Best Graduate Schools."

Rankings are based on ratings by medical school deans and senior faculty in the nation's 125 accredited medical schools and 20 accredited schools of osteopathic medicine.

School of Medicine students learn and care for patients in rural areas of West Virginia as part of the requirements for graduation. They work in partnership with rural communities and other health care providers in rural clinics across the state.

Rural health training at WVU is about education and community service. Forty-eight percent of WVU School of Medicine graduates choose to practice in primary care areas, such as family medicine, internal medicine, emergency medicine, and pediatrics.

The number of physicians who practice in rural, underserved communities has increased by 200 percent in recent years. //2009//

/2009/ Educational Improvements:

Wayne County 21st Century Community Learning Centers (WCCLC) are assisting with the learning and development of school-age children and their families during out-of-school time; before school, afterschool and during the summer months. Twenty-two school-based and community-based programs are serving over 1,500 elementary and middle school students. The goals of the program are to : 1) improve academic performance, 2) increase technology education, 3) increase recreational and physical activities, 4) prevent drug use, 5) reduce negative student behaviors and increase character education, 6) improve school attendance, 7) increase parental and community involvement and support, 8) develop critical thinking, problem solving, teamwork and communication skills, and 9) implant a sense of social responsibility. All activities are aligned with West Virginia Department of Education's 21st Century Learning Skills and Technology Tools Content Standards and Objectives for West Virginia Schools.

/2010/ West Virginia is ranked at the top in the new report grading states on their use of technology in the classroom over the past decade. Education Week's Technology Counts 2009 report, released on March 2009, gives the Mountain State an overall score of 100. The national average was a 82.7. //2010//

/2010/ The Interagency Agreement between Medicaid and Title V is attached in this section. //2010//

/2010/ HIV Testing Pilot Project:
The Family Planning Program (FPP) submitted a proposal to the HIV/AIDS/STD Program in February 2008 requesting oral HIV testing supplies and lab processing for 10 FPP provider sites in response to the federal Title X Family Planning Program encouraging HIV test integration into routine FPP visits. After several months of review and discussion, the HIV/AIDS/STD Program notified FPP that funding was not available to conduct this pilot project. The FPP began to seek alternative funding for oral HIV test supplies and lab processing. In September 2008, FPP received supplemental Title X funding from Region III to conduct a pilot project to increase HIV testing. The purpose of the Project is to assess the need for voluntary HIV testing as part of the routine FP medical exam. An HIV testing pilot project was implemented on December 1, 2008. Twenty-three FPP provider sites were identified as potential participants based upon clinic volume, incidence of HIV in the region and current pre/post testing counseling availability. The pilot project will continue through May 31, 2009, or until the target number of tests (4000) is reached. The target

population includes any female or male presenting for an initial or annual exam. Oral HIV test kits were provided to the selected sites along with client literature. Data collected during this pilot project will be shared with the participating FPP providers, HIV/AIDS/STD Program and the Title X Region III Project Office. Results of this pilot project will determine the need for routine testing in FPP sites and will provide supportive data to justify funding for future testing. Results of this pilot project will be included in the 2009 Progress Report.

Patient Flow Analysis:
The FPP is struggling to maximize efficiency and existing resources while overall support for the programs has remained static. While Title X has not had significant fiscal growth over the last years, they are recognizing the difficulty of administering quality, comprehensive family planning services nationwide. Title X is encouraging use of a computerized software program that would allow the Family Planning network to analyze operations and to identify areas for economy or service improvement. FPP staff recently attended training for Patient Flow Analysis (PFA). FPP staff is available to conduct the PFA and assist with analysis of the study data. This service is provided at no cost to the FPP provider.

The PFA delivers 13 standard reports designed to provide:
•Objective information
•Catalyst for making improvements in the clinic
•Improve customer service
•Improve staff morale

The PFA requires FPP staff to observe a normal work day in the clinical setting and record data into computer software, provided by CDC. This is not a monitoring tool, but an efficiency tool. Findings from the PFA are not shared with anyone but clinic staff during a follow-up meeting. PFA does not require implementation of any clinical changes. The data reports are for information purposes to improve clinical efficiency.

PFA takes approximately 2 days clinic time; an initial meeting (1-2 hours) with staff prior to the actual data collection, day of data collection in the clinic, a follow-up meeting (1-2 hours) with staff to review the outcomes and a review in 6 months to evaluate progress.

New FPP Providers:
A review of FP percent need met data and Family Planning Annual Report (FPAR) data was conducted to identify underserved areas in West Virginia. Three areas were identified as unmet FPP need; the eastern panhandle (Jefferson, Berkeley, Morgan and Mineral Counties), northern panhandle (Hancock, Brooke, Ohio, and Marshall Counties) and north-western West Virginia (Wetzel, Tyler, Wood, Ritchie and Roane Counties). Public notice was published in the state wide newspaper (Charleston Gazette) requesting agencies/organizations interested in providing FP services in any of the listed counties to contact the FPP administrative office and request an application. Applications were mailed to 6 responding organizations. A review committee comprised of 5 individuals evaluated the applications and rated each one based upon experience in reproductive health care, hours of operation, location and projected number of clients to be seen. New FPP provider sites were added in Wood County, Randolph County, Preston County and Doddridge County.

Unplanned Pregnancies:
The Family Planning Program participated in a nationwide "Learning Tour" conducted by the National Campaign to Prevent Teen Unintended Pregnancy (NCPTUP) in April 2008. The West Virginia Perinatal Partnership partnered with NCPTUP to study unplanned pregnancy in the 19-29 year age group, the causes and potential remedies in West Virginia. The "Learning Tour" spoke with professionals, policy makers and young adults

recording their thoughts on unplanned pregnancy. The NCPTUP completed a report on the West Virginia findings. The Perinatal Partnership received funding to explore unplanned pregnancies, based upon findings of the study and a statewide Advisory Committee was organized. The goal is to provide women with information needed to make healthy decisions regarding pregnancy.

RFTS, HAPI (Healthy Start) and Partners In Community Outreach provided in-home education and incorporated "Planning for a Healthy Pregnancy" into their health education curriculum used with clients. In-home educators received protocols in February and began incorporating advanced education in the in-home program. This intiative ended in July 2009. Data will be available by January 2010. The target groups of women served by the initiative were women in the third trimester of pregnancy and the postpartum period.

The FPP purchased educational DVDs, brochures and wallet cards stressing the importance of spacing and planning for a healthy pregnancy to assist RFTS care coordinators in providing in-home education. The FPP also made it possible for the RFTS Regional Lead Agencies (RLA) to become "Special Agreement Sites" for family planning services. The RLAs can order sperimicide and condoms for care coordinators to offer to clients during home visits. Databases for the FPP and RFTS can link and share required data elements. //2010//
An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

Medicaid serves a large portion of the population within the state, including women, infants and children. Approximately 60% of all deliveries of infants are paid for by Medicaid. Within the capacity indicators there is a definite variation in the Medicaid versus non-Medicaid population. The family income eligibility for CHIP was expanded and now covers children in the state who were otherwise uninsured.

The Division of Research, Evaluation and Planning within the OMCFH has received a grant from HRSA for State Systems Development Initiatives since 1996. The Research Divsion has used these funds to increase capacity and access data files throughout the Bureau and beyond. The OMCFH Research Division has access to both birth and death files on a regular basis from Vital Statistics, birth defects data, childhood lead screening data, Medicaid eligibility files, newborn metabolic screening from the State Laboratory, high risk and hearing screening data collected on the Birth Score card through WVU, CSHCN data, and the states's perinatal program data.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	104.5	111.2	164.0	108.9	98.2
Numerator	1064	1132	1670	1109	1000
Denominator	101805	101805	101805	101805	101805
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

based upon 2007 Hospital Discharge Data, HCA

Notes - 2007
2007 Hospital Discharge Data, HCA

Notes - 2006
2006 Hospital Discharge Data, HCCRA

Narrative:
/2009/ Nationally, asthma is one of the leading chronic diseases among children and causes more absence from school than any other chronic disease. Approximately 12% or 42,000 West Virginians under the age of 18 have at some point been diagnosed with asthma by a health care professional. It is estimated that in 2006, 8.4% or 31,000 West Virginia children currently had asthma. Approximately 60% of children under the age of 18 and 60% of public high school students with asthma had an asthma attack in the past 12 months. More than one-third (37%) of public high school students with asthma missed school due to asthma during the 2004-2005 school year. Children under the age of 15 accounted for 23% of asthma hospitalizations in 2006. Between 1996 and 2003, the asthma hospitalization rate was higher in the US than in WV. However, asthma hospitalization rates nationwide have recovered from the 2003 spike and are now slightly lower than the rates in WV. In 2005, there were 17.0 asthma hospitalizations per 10,000 WV residents, compared with 16.6 hospitalizations per 10,000 people nationwide. //2009//

/2010/ In 2008, there was a drop in the number of hospitalizations, however the trend appears to vacillate from year to year. WV has one of the highest smoking rates nationally and second hand smoke is a known irritant for asthma. Appropriately so, tobacco monies are also being used to address environmental factors that increase the risk of developing asthma or exacerbate the disease. Although the OMCFH is not the home of the Asthma Initiative, since it is a disease that affects both children and adults, the OMCFH has a role in prevention via education of parents and children, plus a direct clinical care role which includes: 1) addressing maternal smoking during pregnancy and/or early infancy, and 2) provision of asthma therapy for children to include maintaining pulmonary function, normal activity levels, minimizing emergency room visits and hospitalization, and making available medication to control persistent asthma and "quick relief" medication to treat acute symptoms.

A West Virginia Asthma Coalition consists of members from public health offices as well as community physicians and other interested agencies. The Coalition's role is one of prevention through education, establishing disease reporting parameters and mechanisms enabling tracking of incidence levels, advocacy for inclusion of benefit coverage across all payors for those affected by the disease, and payment for screening and prevention activities. There also remains the responsibility to assure screening, treatment, etc., is available and accessible to all, an assignment which exceeds the scope of health care financing available to OMCFH.

The West Virginia Department of Education, in collaboration with the West Virginia Asthma Coalition, developed a survey for school administration to determine the educational needs of staff. Responses to the survey identified the need for school personnel education directed at emergency care of the child, asthma inhaler legislation affecting in-school use, exercise and asthma, and managing students with asthma.

The WV Bureau for Pubic Health's Asthma and Education and Prevention Program (WV-AEPP) , funded by CDC since 2001, maintains an asthma surveillance system, promotes statewide partnerships, and implements interventions to reduce the burden of asthma in WV. As a member of the Centers for Disease Control and Prevention's National Asthma Control Program, WV-AEPP has a priority goal of decreasing hospitalizations due to asthma complications.

The Asthma Education and Prevention Program distributes quarterly newsletters to individuals,

community organizations, and medical practice sites, discussing management, treatment methods, and the harmful effects of smoking.

Camp Catch Your Breath (CCYB): The dates for the 18th annual camp are set for July 26 through July 31, 2009, at Jackson's Mills. United Hospital Center and the American Lung Association of West Virginia, together with their sponsors and supporters, sponsor the camp for children with asthma. CCYB is week-long, overnight, co-ed summer camp that provides a fun and educational experience for children with asthma - children who might not otherwise get to go to camp. During camp, the children learn by sharing their experiences, making decisions about their conditions and expressing their feelings about having asthma. In addition to the educational components, children participate in games, sports, swimming, and crafts. Campers are supervised by staff from participating hospitals. A physician is present at all times and emergency medical support is readily available. The camp counselors are respiratory specialists. Staff from the Lung Association is also in attendance.

While the camp is co-sponsored by United Hospital Center in Clarksburg, Cabell Huntington Hospital, Camden-Clark Memorial Hospital, Jefferson Memorial Hospital and Ohio Valley Medical Center are also participating.

In the two-year funding cycle (September 2007 - August 2009), the WV-AEPP goal is to maintain, expand and strengthen: 1) the state asthma surveillance system, 2) partnerships to enhance the implementation of the strategic plan, and 3) interventions in community centers and emergency rooms to improve the care and management of asthma. The WV-AEPP will focus on activities to reduce asthma hospitalizations.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	95.0	95.0	98.0	99.3	97.1
Numerator	11630	11685	13101	13808	13431
Denominator	12242	12300	13368	13905	13829
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Fiscal Year 2008 - CMS - 416

Notes - 2006
Medicaid enrollees from July 1, 2005 to June 30, 2006

Narrative:
/2010/ The OMCFH administers the mandated Medicaid EPSDT Program (known in West Virginia as HealthCheck). The HealthCheck Program educates families who receive Medicaid about preventive health care for their children and encourages their participation in the HealthCheck Program while ensuring the following: 1) children are screened/re-

screened according to periodicity tables established by the American Academy of Pediatrics; 2) medical problems identified by examination are treated/referred; and 3) children/families receive transportation assistance and help with appointment scheduling. In WV, in 2008, 97% of children under the age of one (1) who receive Medicaid, received at least one initial or periodic screening. The HealthCheck Program focuses on training of EPSDT providers to assure compliance with program protocols. As part of the Governor's Kids First Initiative all children entering Kindergarten are required to receive a health screen using EPSDT protocol, regardless of insurance carrier.

Since 2007, WVCHIP has continued their partnership with the Office of Maternal, Child, and Family Health's Division of Infant, Child and Adolescent Health, to promote full periodic and comprehensive well child visits recommended by AAP. Health messages focusing on vision, dental, development, and hearing screenings appreared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the "HealthCheck" form as the standard form providers are to use in all well-child exam visits, and this occurred prior to the implementation of Kids First.

Most infants under the age of one in WV are either covered by private insurance or Medicaid. WVCHIP did cover 66 children under the age of one in 2008 down from 106 in 2007. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	96.3	96.1	100.0	100.0	94.1
Numerator	103	99	14	16	16
Denominator	107	103	14	16	17
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
CHIP 2008 Annual Report, date ending June 30,2008. Continuously enrolled children less than or equal to 15 months.

Notes - 2007
2007 CHIP Annual Report - data for fiscal year ended June 30, 2007. Continuously enrolled children less than or equal to 15 months.

Notes - 2006
2006 CHIP Annual Report - data for fiscal year ended June 30, 2006. Continuously enrolled children less than or equal to 15 months.

Narrative:
/2009/ The bipartisan Rockefeller-Kennedy-Snowe CHIP Reauthorization Act of 2007 (S.1224) provided significant new federal resources for children's health coverage that will enable states to substantially expand the number of children in this country who have health care. The legislation

assures states a stable and sufficient source of financing to cover uninsured children. Because of this, West Virginia's Governor Joe Manchin lll signed into Legislation, during the 2007 session, CHIP eligibility expansion up to 300 percent of the federal poverty level. A phase-in eligibility of up to 220 percent of the federal poverty level began July 1, 2007. ***/2010/ In July of 2008, the eligibilily raised to 250% of the FPL. //2010//***

/2010/ Not many infants, under the age of 1, in WV are eligible for CHIP. Most infants under age one are insured by Medicaid (eligible at or below 150% FPL) or private insurance. //2010//

The following projects were implemented in fiscal year 2007:
-WVCHIP continued partnership efforts to promote healthy lifestyles with the West Virginia Immunization Network, Action for Healthy Kids Coalition, West Virginia Asthma Coalition, and the Medical Advisory Council.
-In 2006-2007, WVCHIP continued partnership with OMCFH's Infant, Child and Adolescent Health to promote full periodic and comprehensive well child visits recommended by pediatricians in a "HealthCheck" campaign. Health messages focusing on vision, dental, development, and hearing screenings appeared in Child Care Provider Quarterly Magazine. Through this partnership, WVCHIP identified the "HealthCheck" form as the standard form providers use in all well-child exam visits.
-The West Virginia Immunization Network, the State's Immunization Program and WVCHIP continue working on strategies to implement an immunization campaign targeting adolescents. WVCHIP provided matching funds to Raleigh County to implement the "Take Your Best Shot" adolescent campaign, which began in October, 2007.
-WVCHIP provided flyers and ABC's of Baby Care to include in Day One Packets for distribution to all new mothers at participating West Virginia hospitals.
-WVCHIP materials were included in the State's Immunization Program packets to new mothers through the Right From the Start Coordinators. //2009//

/2010/ WVCHIP continues to collaborate with community partners identified in the State Plan, however, as enrollment has stabilized, efforts to promote public awareness of the program have shifted from an enrollment focus to one of promoting child health awareness and prevention messaging on topics such as childhood health screening, child development, immunizations, and the importance of a medical home. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	82.6	81.5	83.0	75.9	76.7
Numerator	17267	16982	17375	16245	16500
Denominator	20911	20834	20931	21407	21500
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Based upon 2007 Vital Statistics - calculated by 1st trimester with 11+ visits, 2nd trimester wtih 6+ visits and 3rd trimester with 1+ visits

Notes - 2007
2007 Vital Statistics - calculated by 1st trimester with 11+ visits, 2nd trimester wtih 6+ visits and 3rd trimester with 1+ visits

Notes - 2006
2006 PRAMS data

Narrative:
/2009/ According to 2006 WV Vital Statistics, 5.2% of women had 1-5 prenatal care visits, 27.8% of women had 6-10 prenatal care visits, 54.5% had 11-15 prenatal care visits and 11.1% had 16 or greater prenatal care visits. Of women with known prenatal care 81.5% of women began prenatal care in the first trimester, 14.7% began in the second trimester and 3.1% began prenatal care in the third trimester while 0.7% of women received no prenatal care. //2009//

/2010/ WV Vital Statistics 2007, show that 0.6 % of women had no prenatal care while 5.0% of women had 1-5 prenatal visits, 28.2% had 6-10 prenatal visits, 55.0% had 11-15 prenatal visits and 11.2% had 16 or more prenatal visits. Of those women with known prenatal care 82.1% began in the first trimester, 14.5% began in the second trimester and 2.5% began in the third trimester. The number of prenatal care visits received by WV women were up a little in 2007 from 2006.

Availability of prenatal care providers continues to be problematic, see earler report related to capacity. Also, the only board-certified perinatal specialists in WV are located in Charleston, Huntington, and Morgantown, where the tertiary care hospitals are located. Women and babies needing the services of high-risk specialists often have to travel long distances for an appointment. Many do not keep their appointment because of the long distances on difficult WV roads. Telemedicine is being expanded to bring expertise to patients and community-based physicians in rural areas, saving transportation cost and time. In addition, community-based physicians would receive valued support. Telemedicine also gives health care providers access to continuing education lectures that are given at medical schools. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	98.9	98.9	98.5	98.5	98.9
Numerator	214150	212200	207060	204413	204502
Denominator	216516	214500	210181	207606	206729
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
CMS-416 Annual Report Fiscal Year 2008

Narrative:
/2009/ Medicaid paid for a service to 98.5 percent of the children eligible for Medicaid. One in three WV children are eligible for Medicaid. In May, 2006, West Virginia received approval from the federal government to move ahead with a unique and controversial program to restrict access to certain health care services if Medicaid beneficiaries do not sign and/or comply with a "Personal Responsibility Agreement". Known as the "Medicaid Redesign", the centerpiece of the initiative is an agreement that beneficiaries must sign with their doctors, promising that they will comply with a health improvement plan and outling broad patient responsibilities. Beneficiaries who complete and return the agreement receive an "Enhanced" benefits package while those who do not, receive a "Basic" plan. The "Basic" plan restricts prescription drugs and limits mental health services and limits access to physical and speech therapy. The enhanced plan does not include these limits and adds benefits designed to encourage wellness such as weight management and nutritional education. //2009// HealthCheck is West Virginia's name for the mandated pediatric Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Over 200,000 Medicaid-approved children in West Virginia have been eligible to participate in the HealthCheck Program for the past three years. EPSDT's promise to children eligible for Medicaid is the provision of preventive health exams and treatment of all medical conditions discovered during the exams.

Pediatric Program Specialists are assigned to geographical regions to educate, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional providers for underserved areas. This workforce has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school-based clinics and on site EPSDT evaluations. The number of students using school-based health centers (SBHC) has steadily increased over the past few years. The School-Based Health Center Initiative's goal is to develop a coordinated system of health care for children that increases access to primary and preventive care, especially for students who are uninsured, who lack a medical home, or who are at risk for health problems.

The EPSDT Program, administered by the Office of Maternal, Child and Family Health, provides dedicated outreach to eligibles in order to encourage participation and provide technical assistance support to school-based health centers and participating physicians to assure EPSDT compliance. The OMCFH administers the EPSDT Program, and uses the outreach requirement of the federal legislation to encourage families with children to participate in routine, primary preventive care.

/2010/ The EPSDT Program also works closely with the Bureau for Children and Families in assuring that all children in State custody receive an EPSDT screen within three days of placement into DHHR custody. //2010//

Infants whose birth was sponsored by Medicaid and served by RFTS was 36% of all Medicaid sponsored births. Approximately 57% of all WV births were to Medicaid sponsored women, and all infants born to mothers with Medicaid coverage are eligible for Medicaid for the first year of life.

Medicaid beneficiaries with chronic debilitating conditions represent 89.6% of children in the CSHCN Program.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	48.0	48.0	54.0	54.5	56.0
Numerator	19800	19800	22339	22398	22778
Denominator	41244	41244	41353	41073	40691
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Fiscal Year 2008 - CMS - 416

Narrative:
/2010/ The Children's Dentistry Project (CDP) is a component of Oral Health Programs within the Division of Infant, Child and Adolescent Health housed within the OMCFH. Data for FY 2008 indicates that 56% of West Virginia Medicaid recipients ages 6-9 received a dental service. In WV, Medicaid child beneficiaries have financial access to dental services, yet most do not routinely seek care. Failure to keep appointments is the reason WV reports as their lack of dentists to serve the Medicaid population, thus limiting access. It is clear that public health must facilitate opportunities for youth to access dental care by educating children, youth, and their parents about the importance of oral health, and the following depicts a portion of these efforts:

1) The CDP currently has 27 contracts with local health departments, primary care centers and individuals to offer oral health education to students in public schools in all 55 West Virginia counties. Educators offer information about dental hygiene, the need for preventive dental visits, and the dangers of tobacco use. This project was initially provided only to students in Lincoln County but the OHP is working to expand this service to students in Mason, Jackson, and Mingo Counties. 2) The CDP, in partnership with county school systems, Head Start agencies, and other community children's programs, work together to offer a sealant and fluoride rinse program within schools. 3) The CDP contracts with local primary care centers to purchase all supplies and perform all billing functions. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access.

There are significant numbers of West Virginians who do not have a fluoridated water supply, even though the supply may be from a public system. Fluoridation equipment is not expensive and supplies are no more than $3 per customer per year. The savings in future dental caries is 5 to 6 times that amount. For example: For a town the size of New Martinsville (currently not receiving fluoridated water), the annual cost of fluoridation would be $25,500. If only one cavity is prevented in each family, net savings for the community is $124,200 annually.

While State Medicaid Programs are required by federal law to provide dental services to eligible children, enrollees' access to dental care is poor. In 2008, only one in two children in WV Medicaid received a dental service.

The great majority of dental care in West Virginia and across the country is delivered by private practicing dentists, so participation is key to improving access for publicly-sponsored patients. Approximately 2/3 of dentists in West Virginia have agreed to accept Medicaid and CHIP beneficiaries. They, like dentists across the country, cite three primary reasons for their low participation in state Medicaid programs: low reimbursement rates, burdensome administrative requirements and problematic patient behaviors.

OMCFH convened an Oral Health Advisory Board to study policy and procedures necessary to improve oral health access and utilization in West Virginia. This charge by the Legislature is complicated by the fact that the assignment is population-based, and so many West Virginia adults (and some children) lack access to dental health service financing/insurance. For example, West Virginia Medicaid does not provide dental coverage to adult beneficiaries except to alleviate pain and suffering, i.e., extraction. There is no special coverage extended to pregnant Medicaid beneficiaries, although there has been discussion around pregnancy, periodontal disease and preterm labor.

As a part of the West Virginia Advisory study we distributed information gathered by the National Academy of State Health Policy (NASHP) as to the effect raising Medicaid reimbursement rates has on access to dental care. The Advisory Board will also develop a comprehensive state oral health plan which follows current CDC guidelines. The Board includes: WV Department of Education, WVDA, WV Board of Dental Examiners, WVU-SOD, WVDHA, WV Head Start, WV Partners for Oral Health, WV Medicaid, WVPCA, WV Free Clinics Association, WV Council of Churches, WV CHIP, private and public foundations, AAP, private and public insurance companies, 4-H, WV Oral Health Educators, local health departments, school-based health centers, WV Association of School Nurses and others.

Dental highlights during the 2009 Legislative session include:

Permanent rule making that allows dental hygienists to practice under the general supervision of a dentist. General supervision means a dentist is not required to be in the office or treatment facility when a procedure is being performed by a dental hygienist or dental assistant, if the dentist has personally diagnosed the condition to be treated, has personally authorized the procedures, and will evaluate the treatment provided by the dental auxiliary personnel (hygienist or dental assistant).

Expanded duties of dental hygienists and dental assistants to include coronal polishing on children by trained dental assistants. Assistants with 2 years and 3,000 hours of clinical experience qualify to participate in an approved training course. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	18.3	15.2	16.6	10.7	20.4
Numerator	1256	1049	1079	987	1879
Denominator	6856	6901	6489	9196	9233

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
numerator is children under 18 - from CSHCN

Narrative:
The CSHCN Program advances the health and well-being of children and youth with chronic health care needs, including those with cleft lip and palate, neurologic, and cardiac problems. The goal is to facilitate early care, offer consultation and clinical intervention, care management and planning, as well as to support the family and community in the care of children with special health care needs. ***/2010/ The program provides care coordination services to children, age birth to 21, who have a variety of payers such as WV Medicaid, CHIP, PEIA, Blue Cross Blue Shield and other forms of insurance. //2010//*** Components of the Program include: 1) assessment of children with special health care needs and enrollment in clinical care or referral to alternative sources as medically indicated; 2) participate in development of multidisciplinary treatment plans; 3) act as resource support to increase awareness of and need for primary, preventive health care; 4) establishes linkages with sub-specialty physicians, therapists and other providers; 5) CSHCN staff provide care management, including developing and monitoring treatment plans, assisting families with scheduling and transportation, and referral to other community services; and 6) adolescent/adult transition planning, including referral for work/training.

/2010/ The Children with Special Health Care Needs Program provides medical and care coordination services for children birth to 21 years of age. In CY 2008 875 children/youth received services in 31 specialty care clinics throughout the state. Seven thousand, seven hundred thirty seven (7,737) children statewide under the age of 16 receive SSI benefits. Of these children 608 or 8% received services from the CSHCN Program. Not all conditions that qualify children for SSI are eligible for participation in the CSHCN Program. For example, CSHCN does not have capacity, professionally or fiscally, to care for autism, serious emotional disorders etc., conditions which often trigger SSI eligibility. //2010//

There were 879 SSI recipients under 18 years of age who also received CSHCN services. As of December 2008 there were 9,233 children in WV under the age of 18 receiving SSI benefits indicating that the CSHCN Program served 9.5% of WV children under the age of 18 who received SSI benefits.

In CY 2008, 1,536 clinic visits took place which included both enrolled clients and those in pending status receiving a first time evaluation in 31 specialty clinics throughout the state. There were 1,630 enrolled clients in the CSHCN Program by the end of 2008.

The CSHCN Program is committed to assisting families with SSI applications and expediting the SSA/Disability Determination process. To meet this goal the CSHCN Program continues to partner with the SSI Disability Determination Unit to share medical information on children seeking SSI.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	10.4	7.4	9.5

Notes - 2010
2007 Vital Statistics

Narrative:
/2010/ Right From The Start (RFTS) perinatal program data from 2008 data reflects the average birth weight for an infant born to Project participants was 6.96 pounds. While this is to be applauded, not all eligible pregnant women participate in this strictly volunteer Program.

The high incidence of low birth weight is concentrated in a small number of counties. Activities to address this include RFTS follow-up to discuss nutrition during pregnancy, enrollment in WIC, and education on the importance of adequate and early prenatal care and smoking cessation.

Planning and spacing for pregnancy is a key factor in reducing low birth weight incidence. The RFTS Project personnel encourage participants to choose a method of birth control early in the pregnancy in order to prevent repeat or unintended pregnancies. Documentation of family planning discussion is required as part of RFTS Project protocol prior to case closure at sixty (60) days postpartum. RFTS data for 2007 show 67% of postpartum participants chose a birth control method, an increase of 4% from 2005.

Warning signs of preterm labor are printed on brightly colored labels and shipped to RFTS enrolled obstetrical providers along with each order of prenatal vitamins from Materials Management. These vitamins are supplied at no charge to enrolled providers and are dispensed to pregnant women who are ineligible for Medicaid coverage but are eligible for assistance with funding of their obstetrical care through Title V.

The RFTS Project continues to work collaboratively with West Virginia OB providers, March of Dimes, WIC, American Lung Association, West Virginia Perinatal Partnership, and many other groups to educate women on the health consequences of premature births. The OMCFH remains dedicated to reducing the number of babies born early and/or too small.

The RFTS Project continues to provide intense education for women who participate in services, and continues to be the statewide network through which the March of Dimes provides education, literature, and information on prematurity awareness to West Virginia residents and medical providers. March of Dimes programs focus on education about the signs of preterm labor and research causes.

The OMCFH will use outcomes from the Perinatal Partnership to plan future risk reduction activities for WV pregnant women. One sure to be addressed is elective C-Sections which are occurring at less than 39 weeks gestation, since this may be contributing to LBW incidence. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	payment source from birth certificate	9.3	4.6	7.4

Notes - 2010
2007 Vital Statistics

Narrative:
/2010/ Almost 60% of births in WV are to women whose delivery was paid for by Medicaid. Because WV is primarily caucasion, less than 5% of births are to women of a minority race. Statistics show an increased incidence of poor perinatal outcomes among minority women, some 800 women per year, and women whose delivery was paid for by Medicaid. Certain perinatal risk factors appear to be more prevalent among this population. Prenatal care is important in evaluating risk, promoting health, and managing complications in pregnancy, yet disparity of and access to care place these vulnerable women at increased risk. //2010//

/2009/ The WV Perinatal Wellness Study evaluated changes in the infant mortality rates and percent of low birth weight babies, assessing what perinatal preventive health programs exist and identifying ways to improve perinatal wellness. The Study organizers involved stakeholders concerned with perinatal health, that included the OMCFH Office Director, Division of Research, Evaluation and Planning Director, the Division of Perinatal and Women's Health Director, hospital NICU physicians, insurance company personnel and representatives from numerous other public agencies and private organizations. //2009//

/2010/ In the last several years, West Virginia's infant mortality rate and percent of low birth weight babies have increased, rating WV well below other states and below the national average for these two indicators of child well being. According to 2007 WV Vital Statistics, over one out of six (17.8%) infant deaths were due to SIDS. Approximately one in six (16.6%) were the result of congenital malformations, while 49.1% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birth weight (10.4%) The overall infant mortality rate for West Virginia in 2007 was 7.4 deaths per 1,000 live births whereas the overall infant mortality rate for the United States in 2006 (last date available) was 6.9 per 1,000 live births.

According to WV SIDS Project there were thirty-two (32) Sudden Unexplained Infant Deaths (SUID) in West Virginia in 2007. This was 12 less than reported in 2006. All infants were less than seven (7) months of age, 84% of the infant deaths involved co-sleeping, 72% involved hazardous bedding and 84% involved maternal smoking during pregnancy. Almost all (90%)of the SUIDS deaths were to infants who received Medicaid. //2010//

RFTS care coordinators continue to provide anticipatory guidance to participating families on risks of co-sleeping, importance of placing infants on their back to sleep, importance of smoking

cessation during pregnancy and importance of creating a smoke free environment for all infants and children.

West Virginia continues to struggle with a high rate of smoking during pregnancy which is one of the leading associated risks for low birth weight and infant deaths. Over one-fourth (26.8%) of WV births in 2007 were to mothers who smoked during the pregnancy while national figures from 2005 (last data available) show that 10.7% of women giving birth reported smoking during pregnancy.

In WV, approximately 60% of all pregnant women receive prenatal care through Medicaid. The RFTS Maternity Services also provides coverage for additional women who are ineligible for Title XIX. In 2008, 717 pregnant women who were denied WV Medicaid applied to RFTS Maternity Services for financial assistance with the cost of their obstetrical care and 453 had a portion of their prenatal care costs covered. Funding for RFTS Maternity Services is provided by federal Title V, WV Medicaid and WV State appropriations.

The Right From The Start (RFTS) Project in collaboration with the Office of Maternal, Child and Family Health (OMCFH) Newborn Hearing Screening and SIDS Projects conducted four statewide Designated Care Coordinators' (DCC) training sessions in 2007. Topics included Sudden Infant Death Syndrome, Newborn Hearing Screening and RFTS Updates.

A reminder post card is being sent out to all new parents of infants to remind them to: 1) put their infant to sleep on its' back; 2) do not sleep or let others sleep with your infant at anytime; 3) do not use soft/fluffy bedding for your infant; and do not smoke around your infant and/or other children. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	78.3	86.1	82

Notes - 2010
2007 Vital Statistics

Narrative:
/2010/ Since the Right From The Start Project was first initiated in 1989, access to first trimester prenatal care has shown improvement from 69.7% to 81.5% in 2005, remained at 81.5% in 2006 and increased slightly to 82% in 2007. Intense care coordination and support are provided by RFTS staff to Medicaid and Title V eligible pregnant women in WV.

Early preventive prenatal care and education are recognized as the most effective and cost efficient ways to improve pregnancy outcomes. West Virginia's Perinatal Program, Right From The Start Project (RFTS), was birthed in 1989 as a partnership between OMCFH and Medicaid to provide access to early and adequate prenatal care to low-income pregnant women and infants. Currently, RFTS provides comprehensive perinatal services to low-

income women up to sixty (60) days postpartum and care coordination for Medicaid eligible infants up to one (1) year of age. Right From The Start also provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit.

Results from a study conducted by the WV Perinatal Partnership reveal the need to increase the number of perinatal care providers in underserved counties. In 2007, the Partnership conducted a statewide study to identify private obstetrical practices in the state that might benefit from being matched to an existing Federally Qualified Health Center (FQHC) site. This designation would allow the medical professionals to have medical liability coverage under the Federal Trades option. The group also worked with the 2009 WV State Legislature to support elements identified to improve perinatal health. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	73	81	77

Notes - 2010
2007 Vital Statistics

Narrative:
/2010/ According to 2007 WV Vital Statistics, 28.2% of women had 6-10 prenatal care visits, 55% had 11-15 prenatal care visits and 11.2% had 16 or greater prenatal care visits. WV Vital Statistics also shows that in 2005 and 2006 81.5% of women began prenatal care in the first trimester. In 2007, 82% of women began their prenatal care in the first trimester.

Ensuring access to health care for low income women and children has been an ongoing concern for state and federal officials. The Bureau for Medical Services (Medicaid) and Office of Maternal, Child and Family Health (OMCFH) have worked collaboratively to develop special initiatives that extend support services to women and infants at risk of adverse health outcomes. This partnership has not only expanded the state's capacity to finance health care for women and children, but has also strengthened the delivery of care

by establishing care protocols, recruiting medical providers and developing supportive services such as case management and nutrition counseling which contribute to improved patient well being.

The WV perinatal program known as the Right From The Start (RFTS) Project worked with 83 community agencies throughout WV, under contract, to provide care coordination and enhanced education services to low-income high risk pregnant women and infants. Approximately 165 Designated Care Coordinators (DCCs), who are Registered Nurses and Licensed Social Workers, have been dedicated to the core public health function of assisting with access to early and adequate prenatal health care. In addition to RFTS DCCs, there were 76 obstetricians, nurse practitioners, nurse midwives and family practice physicians in WV and bordering states that have a Letter of Agreement with the Project to provide quality obstetrical and delivery care to pregnant women.

WV has two numbers, with four toll-free lines handling over 14,000 calls annually. The toll-free responders are licensed social workers and nurses. These professionals assist callers, some of whom are pregnant women, in receiving financial support and securing prenatal care. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	220

Narrative:
/2010/ As of June 30, 2008, 13,069 infants under the age of one year were covered under Medicaid and 73 infants under the age of one were covered by WVCHIP. This population had almost a 100% rate of having a primary care visit within this first year of life.

West Virginia Governor, Joe Manchin lll, signed into legislation during the 2007, expansion of WVCHIP eligibility of up to 300 percent of the federal poverty level. A phase-in eligibility of up to 220 percent of the federal poverty level began July 1, 2007. On July 1, 2008, eligibility for CHIP was raised to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2008	 133 100 100
INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.		POVERTY LEVEL SCHIP
Medicaid Children	2008	
(Age range 1 to 5)		220
(Age range 6 to 12)		220
(Age range 13 to 18)		220

Narrative:
/2010/ WVCHIP has worked closely with all partners and entities identified in its State Plan, however, the West Virginia Healthy Kids and Families Coalition has played a pivotal role in working with community based partners to reach uninsured children across the State of West Virginia. This is the Coalition's final year as a grant recipient of the Robert Woods Johnson Foundation's "Covering Kids Project." This year's collaborations included media campaigns and community outreach grants in targeted counties. During the summer months alone, over 75 community events were held featuring WVCHIP promotion or outreach in some form throughout West Virginia in an effort to increase enrollment and awareness of the program along with a message focused on the importance of immunizations. As enrollment has increased, the partnership has evolved in working on health awareness campaigns, such as childhood obesity, immunizations, and the importance of a medical home.

Based on survey data from "Health Insurance in West Virginia", WVCHIP continues to prioritize/target outreach efforts to fifteen (15) counties of the State with either higher numbers or percentages of uninsured children.

The faith community plays a vital role in supporting families and nurturing the development of children, by integrating faith, access to care and health of the whole person. Health ministries, parish nurse programs, congregations and other faith-based organizations are getting acitvely involved in tending directly to the health concerns of their members and the community. Faith organizations that sponsor community-based programs such as child care centers, food pantries and summer camps are becoming more attentive to the problems children face.

For this reason, WVCHIP collaborates with the faith community in an effort to educate and support families in obtaining health care coverage and promoting healthy lifestyles.

The WVCHIP has partnered with Programs within OMCFH that include HealthCheck, Children's Dentistry, Birth to Three (Part C) and Right From The Start to assist in coordinating outreach efforts.

HB 4021, the Health Care Reform bill, passed the last day of the 2006 legislative session. The best part of HB 4021 is the expansion of the WVCHIP. The WVCHIP currently insures children in families with incomes below 250% percent of the FPL, which began July 1, 2008. HB 4021 increases this eligibility to 300 percent of the FPL, which has been reported to be $60,000 a year for a family of four. It is projected that 4,000 plus children will, over the next several years, enroll in CHIP as a result of this expansion. The children in families between 200 and 300 percent of the FPL will be required to pay monthly premiums, and deductibles and copayments. The expansion of CHIP is projected to increase from 94% of West Virginia children who currently have health insurance to 97%. This will nearly be universal health care coverage for children in West Virginia. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06	YEAR	PERCENT OF

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Pregnant Women	2008	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	

Notes - 2010
Pregnant women are not cover under CHIP. All teen-age pregnancies are covered by Title V.

Narrative:
/2010/ The percent of the federal poverty level (FPL) for Medicaid eligibility for infants up to one year of age and pregnant women is 150%. WVCHIP does not provide medical coverage for pregnancy but refers all pregnant teens to the OMCFH/Title V for coverage.

Medicaid and the OMCFH share a common commitment to the goal of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. These agencies also recognize the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding for targeted populations, targeted outreach, risk reduction education, and development of comprehensive programs that address both medical and behavioral issues.

Early preventive prenatal care and education are recognized as the most effective and cost effective ways to improve pregnancy outcomes. Right From The Start provides direct financial assistance for obstetrical care for West Virginia pregnant women who are uninsured or underinsured and are above income guidelines for Medicaid coverage. These pregnant women may qualify for assistance for prenatal care if they are a WV resident, have income between 150%-185% of the federal poverty level, are a pregnant teen age 19 or under, or are a non-citizen. Under this Title V funded service, women who have no funding source for prenatal care coverage or have not yet been approved for coverage can receive assistance for payment of their first prenatal visit, ultrasound, and routine laboratory procedures if ordered on their first visit. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth	3	Yes

certificates and Medicaid Eligibility or Paid Claims Files		
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:

/2010/ The Division of Research, Evaluation and Planning within the OMCFH has received a grant from HRSA for State Systems Development Initiatives since 1996. The Research Divsion has used these funds to increase capacity and access data files throughout the Bureau and beyond. The OMCFH Research Division has access to both birth and death files on a regular basis from Vital Statistics, birth defects data, childhood lead screening data, Medicaid eligibility files, newborn metabolic screening from the State Laboratory, high risk and hearing screening data collected on the Birth Score card through WVU, CSHCN data, and the states's perinatal program data. The Research Division collects and houses the following data sets and Projects:

The Birth Defects Surveillance System (CARESS - Congenital Anomolies Research, Education and Surveillance System) is currently operating as a passive system. There are MOU's in place with the birthing facilities across the state and the system relies upon them to submit monthly reports which include infants born with defects meeting required diagnosis fields.

WV PRAMS was one of the initial states funded by CDC in 1987 and began collecting data in 1988 and has been actively doing so since that time. WV PRAMS data is used for several of the national and state performance measures.

Newborn hearing screening data originates on the Birth Score card from WVU which is financed by OMCFH, and is sent to OMCFH weekly. Infants who fail or were not screened are followed by nurses/social workers with the Right From the Start Project who receive a direct referral from the Birth Score Office.

Childhood Lead Poisoning Prevention surveillance is financed through a CDC grant and the OMCFH maintains screening and confirmatory results. A social worker and/or nurse will follow-up with any child who has a positive result greater than or equal to 10mcg/dl. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2010

Narrative:
/2009/ The 2007 Youth Risk Behavior Survey (YRBS) was completed by 1,393 students in 34 public high schools in West Virginia during the spring of 2007. The results are representative of all students in grades 9-12.

The weighted demographic characteristics of the sample are as follows:
Males 51.1% Females 48.9%
9th grade 28.6% 10th grade 25.6% 11th grade 23.4% 12th grade 22.0%
White 93.8%
African American 4.5%
Hispanic/Latino 0.7%
All other races 0.5%
Multiple races 0.5%

Students completed a self-administered, anonymous, 87 item questionnaire. Survey procedures were designed to protect the privacy of students by allowing for anonymous and voluntary participation. Local parental permission procedures were followed before survey administration. The YRBS is one component of the Youth Risk Behavior Surveillance System developed by the Centers for Disease Control and Prevention in collaboration with representatives from 71 state and local departments of education and health, 19 other federal agencies, and national education and health organizations. The Youth Risk Behavior Surveillance System was designed to focus the nation on behaviors among youth related to the leading causes of mortality and morbidity among both youth and adults and to assess how these risk behaviors change over time. The Youth Risk Behavior Surveillance System measures behaviors that fall into six categories:

1. Behaviors that result in unintentional injuries and violence;
2. Tobacco use;
3. Alcohol and other drug use;
4. Sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies;
5. Dietary behaviors; and
6. Physical activity.

School Level - All regular public schools containing grades 9, 10, 11, or 12 were included in the sampling frame.
Schools were selected systematically with probability proportional to enrollment in grades 9 through 12 using a random start. Eight schools were sampled with certainty because they had a higher proportion of minority students.

Class Level - All classes in a required subject or all classes meeting during a particular period of the day, depending on the school, were included in the sampling frame. Systematic equal probability sampling with a random start was used to select classes from each school that participated in the survey.

Percentage of students who smoked cigarettes on one or more of the past 30 days = 27.6% overall; 26.7% for males and 28.4% for females; 25.4% of ninth graders; 27.0% of tenth graders; 29.9% of eleventh graders; and 27.7% of twelfth graders.

Percentage of students who used chewing tobacco, snuff, or dip on one or more of the past 30 days = 14.8% overall; 27.0% for males; 2.2% for females; 16.4% for ninth graders; 15.5% for tenth graders; 14.7% for eleventh graders; and 12.0% for twelfth graders.

Percentage of students who ever smoked cigarettes daily, at least one cigarette every day for 30 days = 19.5% overall; 19.1% for males; 20.1% for females; 16.2% for ninth graders; 18.0% for tenth graders; 25.1% for eleventh graders; and 19.5% for twelfth graders. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Office of Maternal, Child and Family Health, Bureau for Public Health, Department of Health and Human Resources, is the "single state agency" for maternal and child health in West Virginia. The OMCFH plans, promotes and coordinates a statewide system of comprehensive health services for women, infants, children, adolescents, and families of children who have special health care needs. The Office is known for longstanding community partnerships between the public and private sector which has ultimately resulted in improved health status and access for maternal and child health populations.

The Office of Maternal, Child and Family Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreements. The exception to this format is CSHCN, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred. It is also important to note that the State's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C/IDEA. In addition, OMCFH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff employed by EPSDT, who serve as technical resources to the medical community. The West Virginia Office of Maternal, Child and Family Health, in collaboration with multiple agencies, family groups, and individuals, has determined several needs across the service system. The needs, as identified, have been linked to Healthy People 2010 Objectives when possible and are listed by targeted populations; i.e., perinatal, children, adolescents, and children with special health care needs as discussed in the needs assessment summary section.

Families of children with special health care needs require the same sorts of support as do families with children who do not have special needs; that is to say, they require basic health care, education, recreation, socialization, transportation, and other systems to support them in their roles as family members and to help them raise children to be healthy, responsible, competent adults. All families need these systems to be available, accessible, and responsive to their needs.

As a result of multiple surveys and public forums, several overall system needs became apparent. Within the Direct Health and Enabling Services category, West Virginia is severely lacking in respite services. Respite services are almost non-existent, even for high need, targeted population groups like Medley class members who were previously institutional residents. In addition, all focus groups reflected the importance of self-determination needs in the state. The State OMCFH received multiple documentation that reinforces this priority need.

Within the Population-based Services category, surveys and public forums, the Medley class survey and the Developmental Disabilities Council survey, show that oral health services are cited as the greatest need among adults with disabilities. There is no oral health care financing for adults in that Title XIX does not offer coverage and the previously referenced Pre-employment Project, administered by OMCFH is limited to adult TANF populations returning to the work force.

Also, even when children have health care financed (Medicaid), there is poor utilization of oral health services. Finally, survey results confirm that vocational transition services are in need of renewed support in West Virginia. Approximately 1/3 of survey responders indicated the need for children to receive transition or vocational planning.

Causes of infant death, low birthweight and maternal smoking must be continued to be addressed. Within the Infrastructure building category, recruitment and retention of qualified medical and other service delivery personnel in WV must receive priority attention in the future. Moreover, insurance systems within the state infrastructure require modification to better accommodate children and families in WV. Recognition of CSHCN services to include reimbursement for non-traditional services such as intervention by licensed developmental specialists and other professionals must become a priority.

/2010/ Children who are placed in foster care are often children who need increased medical and mental health attention as the result of abuse and/or neglect. Because children often move within the foster care system it is important to track services and ensure that the child has a medical home who can manage the child's health plan. OMCFH is in current discussions with the Bureau for Children and Families to allow the CSHCN Program to case manage the health needs of those children who have been placed in foster care. //2010//

B. State Priorities

Each current state performance measure was selected because of the health status of the respective population and based on information derived from the Needs Assessment completed in 2005.

Although West Virginia has financial woes and many health care issues such as smoking among pregnant women, infants born prematurely, infants born with low birth weight, obesity and asthma, the WV OMCFH has woven together a patchwork of funding streams to create a system of care for women, infants, and children, including adolescents and those with special health care needs. The WV OMCFH has developed strong partnerships across the State with the medical community, private sector, as well as community health centers and local health departments, all in an effort to assure access. Medicaid has purchased services for their beneficiaries at the request of Title V but they, too, are facing financial woes.

It is clear that we cannot support all current programs and services at the existing level. In response to budget shortfalls, the WV OMCFH has advocated for the purchase of those services most critical to the health of maternal and child populations--family planning, prenatal care, support of EPSDT, population based surveillance programs, CSHCN services, etc. Another strategy that the WV OMCFH has undertaken is reduction of cost wherever possible. The Family Planning Program formulary has been changed to accomodate the purchase of generic treatment medications and contraceptives. These pharmaceuticals are purchased en mass and stored at a government operated warehouse that is supported by multiple programs, including West Virginia Healthy Start/HAPI. Recently, the data entry staff were merged with the Finance Division to improve capacity. With the constant use of computers and scanning equipment, secretarial staff have not been replaced in some cases. West Virginia is also efficient with resources, often administering programs and services that are used by multiple payor sources such as Title XIX and XXI. To assure that federal resources are maximized, all uninsured children and pregnant women seeking services must apply for Title XIX. If the patient is ineligible for the Title XXI or Title XIX, Title V resources may be used to pay for their care.

The West Virginia five year needs assessment is a work in progress throughout the year, every year. In order to ensure that adequate health care is available we must continually ask our customers if their needs are being met and use data to support outcomes. With limited resources, it is essential to target areas that will have the greatest impact in improving overall

health outcomes.

Through the participation of our medical advisory boards, population targeted focus groups, workgroups and other agencies who conducted surveys of shared constituencies throughout the State and use of qualitative and quantitative data, the following priorities were established for the MCH population as follows:

A. Pregnant women, Women of childbearing age, Mothers and Infants
   1. Decrease smoking among pregnant women
   2. Reduce the incidence of prematurity and low birth weight
   3. Reduce the infant mortality rate
B. Children and Adolescents
   1. Decrease the incidence of fatal accidents caused by drinking and driving
   2. Increase the percentage of adolescents who wear seat belts
   3. Reduce accidental deaths among youth 24 years of age or younger
   4. Assure that children and families access health care financing and utilize services
   5. Reduce smoking among adolescents
   6. Reduce obesity among the State's population
C. Children with Special Health Care Needs
   1. Maintain and/or increase the number of specialty providers in health shortage areas
   2. Assure that children and families access health care financing and utilize services
   3. Increase Newborn Metabolic Screening to include the 29 nationally recommended tests

/2010/ (This priority was deleted as it was met in February 2009). //2010//

If every West Virginian is to have improved health status, we need to help families plan and space pregnancy. This has continued to be a challenge, and even with 150 family planning clinics offering services statewide, we still have unintended pregnancies that ultimately have implications for child well being and family functioning.

Following are additional needs by the levels of the pyramid:

Direct and Enabling Services
1) Key insurance systems within the state require modification to better accommodate the needs of children and families in WV. For example the Public Employees Insurance Program does not provide coverage for hearing aids so CSHCN must purchase the equipment.
2) Persons with disabilities have declared the right to self-determination and advocacy as a WV priority. Included in this declaration is the issue of independent living, meaningful employment opportunity, etc.
3) The utilization of health care services by adolescents needs to increase and additional resources dedicated to affecting behavioral changes such as increased use of seatbelts, decreased use of alcohol and tobacco, increase in the number of adolescents abstaining from sexual activity, and decrease in school drop outs.
4) Decrease smoking among pregnant women.
/2010/ 5) PEIA medical insurance coverage of dependents does not include contraceptives or prenatal care/birth of a dependent's child. This contributes to the total number of unintended births in WV each year. //2010//

Population-Based Services
1) Quality contraceptive health services must be universal as a means of supporting healthy families and reducing unintended pregnancy.
2) All children must have a source of health financing and a medical health home.
3) Oral health services in WV should be improved, and their availability augmented, both for children and adults, especially adults with disabilities. Oral health must be integrated into general health.
4) Attention must be given to causes of infant death in WV - reduce the infant mortality rate.
5) Increase the Metabolic Newborn Screening panel to include all nationally recommended tests.

Infrastructure
1) Recruitment and retention of qualified medical and other service delivery personnel in WV must be given increased attention, including use of paid stipends.
2) Specialty medical services for children with chronic debilitating conditions are a priority as is the improved availability of obstetrical services.
3) An adequate supply of safe and enriching center-based care must be available where acceptable relative care is unavailable with adequate subsidy to allow parents to work.
4) To reduce the proportion of women smoking during pregnancy.
5) To reduce the proportion of unintended pregnancies.
6) To increase the proportion of women receiving first trimester prenatal care whose prenatal care is paid for by Medicaid.
7) To increase the proportion of women >18 receiving Pap smears within the preceding three years.
8) To increase the proportion of eligible children who receive EPSDT services.
9) To identify as early as possible all children at risk of chronic or debilitating conditions and arrange for appropriate care.
10) To increase the proportion of age appropriate children screened for blood lead.
11) To increase the number of children receiving oral health care, with special emphasis on children whose health care is paid for by CHIP and Medicaid.
12) To increase the proportion of women >50 receiving mammograms within the preceding two years.
13) To reduce the incidence rate (per 100,000) of females aged 15-19 years diagnosed with Chlamydia.
14) To support STD screening in Family Planning clinics to assure early identification of patients in need of treatment.

/2010/ According to America's Health Rankings 2008 through the United Health Foundation, WV ranked 39th up from 44 in 2007. Strengths noted included strong public health funding at $121 per person, a low prevalence of binge drinking at 10.5% of the population, a low violent crime rate at 275 offenses per 100,000 population and a low incidence of infectious disease at 9.5 cases per 100,000 population. West Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time as was the case this year. Challenges noted included a high prevalence of smoking at 26.9% of the population, a high prevalence of obesity at 30.3% of the population, many poor mental and physical health days per month at 4.2 days and 5.1 days, respectively, in the previous 30 days, a high percentage of children in poverty at 24% of persons under age 18, high levels of air pollution at 15.5 micrograms of fine particulate per cubic meter and many preventable hospitalizations with 114.4 discharges per 1,000 Medicare enrollees.

Significant changes from 2007 to 2008 included the rate of uninsured population decreased by 9%, the percentage of children in poverty increased by 13%, the prevalence of smoking increased by 5% and since 1990 the violent crime rate has increased by 99%. The percentage of children immunized ages 19 to 35 months, increased from 77.8% in 2007 to 80.7% in 2008. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	19	18	25	27	26
Denominator	19	18	25	27	26
Data Source					Newborn Metabolic Screening
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
from state lab

a. Last Year's Accomplishments
The West Virginia Newborn Screening Program, housed within the Office of Maternal, Child, and Family Health within the Bureau for Public Health, has partnered with the State Laboratory and expanded newborn screening to include twenty-nine (29) disorders which adheres to national standards recommended by the United States Department of Health and Human Services Secretary's Advisory Committee on Heritable Disorders and Genetic Diseases. The full panel of screens was implemented on February 2, 2009.

Newborn Metabolic Screening is a critical public health function by which all newborns are screened shortly after birth for selected disorders with potentially adverse consequences that can be identified and treated before the illness becomes apparent. For many years, even before mandatory Legislation, the Office of Laboratory Services (OLS) worked in tandem with the Office of Maternal, Child and Family Health (OMCFH) to develop capacity to expand the newborn screening panel. Prior to 2005, WV screened for only five disorders, while in 2007 WV had the ability to screen for ten disorders and on February 4, 2009 WV began screening for all 29 nationally recommended disorders. It is the partnership between the Office of Laboratory Services and the Office of Maternal, Child and Family that has allowed this expansion to occur while also being able to provide follow-up and genetic services to all infants that are born within WV borders. The WV Newborn Screening Program boasts coordination of services between birthing facilities, insurance companies, West Virginia University who provides genetic and cystic fibrosis expertise, as well as, with the endocrine, metabolic/genetic and hematology specialists across the State.

In 2008, 99% of infants born in the state of WV received newborn screening. In conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project ensures that infants are screened for inborn errors of metabolism before hospital discharge. All abnormal test results are followed by Office of Maternal, Child and Family Health staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at West Virginia University. The Office of Maternal, Child and Family Health provides, free of charge, regardless of family income, formula for those with confirmed PKU. The OMCFH, using Title V dollars, in the past reimbursed the State Lab for all newborn screening specimens. With the passage of the

Newborn Screening Rules during the 2008 Legislative session, the Bureau for Public Health is now able to bill the hospitals for every infant who receives a screen. The cost of the newborn screening system is included in this charge.

The Genetics Program at West Virginia University provides genetic clinics at 6 strategic locations throughout the state, offering diagnosis, treatment and counseling and was historically funded using Title V dollars. The Genetics Program costs, associated with newborn screening are now included in system charges, since they provide medical support for primary practitioners serving affected newborns.

Staff routinely visit birthing hospitals as a means of identifying and resolving any problems or concerns. Linkage of data from the State Laboratory and the Project have been reestablished creating a more efficient process.

Courier service, using UPS, to pick up specimen at the hospital and deliver to the State Lab daily, is in the planning stages.

Educational information on the expanded panel of disorders has been developed for use by physicians and families.

The Newborn Screening Program website is continually updated to include progress on expansion efforts and information on disorders as well as establishing links to supportive information.

A training tape, to be used at the hospitals, on specimen collection technique is being developed by the State Laboratory.

Expanding newborn screening incrementally has afforded us the opportunity to build State laboratory capacity as well as to begin billing hospitals to recoup system costs between expansion phases.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All abnormal test results are followed by OMCFH case management.		X		
2. The Pediatric Genetics Program at WVU provides six subspecialty clinics throughout the State of West Virginia.				X
3. An active advisory committee assists with policy and program development.				X
4. The NBS Project staff work collaboratively with the State Lab to ensure screening before hospital discharge.				X
5. Formula for PKU patients is provided free of charge, regardless of income, by OMCFH.		X		
6. Linkage of data between OMCFH and the State Lab creates efficiency.				X
7. Formal relationships have been developed with Schools of Medicine to assure availability of medical experts.				X
8. WV currently screens for 29 disorders (includes hearing).			X	
9. The Bureau for Public Health generates revenue by billing the birthing hospital for each live birth for newborn screening.				
10.				

b. Current Activities
It is the goal of the WV Newborn Screening Program to screen every newborn in WV for disorders to ensure diagnosis and treatment before the consequences of the disease become apparent ensuring the greatest opportunity to live a normal, productive life. Long-term benefits include a better quality of life for the child and his/her family and considerable cost savings for the insuring payers and the taxpayers of the State of West Virginia.

The OMCFH Newborn Screening Program staff and the infant's physician are immediately notified by the State Laboratory of all abnormal screening results. In turn, the OMCFH staff discusses with the infant's parents/legal guardian and the primary care physician the need for a repeat screening or a confirmatory test. The OMCFH staff tracks each newborn with an abnormal test result to be certain that the newborn receives prompt and appropriate care. Since initial screening tests give only preliminary information, more precise testing must follow. Thus, an abnormal screening result indicates that further testing is necessary to confirm or eliminate the diagnosis suggested by the screened disorder. Infants with an abnormal screening result are also referred to an endocrinologist, a hematologist, a pediatric pulmonologist and/or to the State's only pediatric geneticist. All referred newborns undergo confirmatory testing and receive treatment if indicated. Newborn screening tests are only performed by the State Laboratory.

c. Plan for the Coming Year
The Office of Maternal, Child and Family Health will maintain its relationships with the State Laboratory, the Newborn Metabolic Advisory, WVU Genetics Program, birthing facilities, Medicaid, insurance companies and the March of Dimes. WVU Genetics, with the Newborn Metabolic Program financial support, is seeking additional nutritional counselors, clerical staff and an additional geneticist to work with the State's only geneticist, Dr. Hummel, because of the expanded panel. The follow-up component of the Newborn Metabolic Screening Program is housed within OMCFH and an additional follow-up nurse was hired and is currently in training.

Processes were developed and will be refined as necessary to purchase supplements needed for those infants diagnosed with a disorder. Partnership with WIC will continue to enable the infant to receive nutritional products that he/she may be eligible for beyond that provided for by the OMCFH.

Information on the more recently added newborn disorders is being developed to be given to physicians. A new brochure for families was developed and is being distributed to the hospitals and OB/GYNS to be given to expectant and/or new parents.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75	60	65	56.1	65
Annual Indicator	56.1	56.1	56.1	56.1	56.2
Numerator			39000	39060	39100
Denominator			69567	69567	69567
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	60

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Parents or legal guardians are involved in the decision making for their child through the Client/Family Assessment process and the development of the Client/Family Care Plan. A multi-disciplinary team approach is used to provide care-planning and care-coordination to CSHCN and Birth To Three Part C/IDEA participants. The multi-disciplinary team includes the child/parent, physicians, nurses, social workers, therapists, school systems, vendors and community services supports who are providing care for the child. Team members, led by the CSHCN nurse and/or social worker, collaborate with the family in developing an appropriate, comprehensive care plan for the child.

Birth To Three, Part C/IDEA for infants and toddlers with developmental disabilities, assures that families have a choice of credentialed practitioners to provide services agreed upon during the Individual Family Service Plan (IFSP) development. Families also have access to other families who have similiar experiences and can provide support and resource information. These parent to parent resources are available statewide with a parent coordinator assigned a specific geographic region of the state. Eight parent to parent coordinators are paid by BTT. In addition, families are seated on the Interagency Coordinating Council/ICC alongside other stakeholders. The ICC is charged with providing advise and guidance to the state Part C system administered by MCFH.

Care plans for children under 18 participating in CSHCN are developed along with their parents to assure medical, social and appropriate developmental issues are accommodated. The CSHCN Program, using Title V funds continues to support the Parent Network, administered in partnership with the Center for Excellence in Developmental Disabilities (UAP) at WVU, although staff are strategicly located throughout the state. These Parent Network Specialists assist families with making informed choices about healthcare to promote treatment options, community resources, and conduct outreach activities to families, healthcare professionals and other appropriate groups.

To facilitate parent involvement in all facets of MCFH, we need to identify barriers such as the use of acronyms. To ensure State staff are "doing our part" we've participated in the WV Developmental Disabilities Council training "Project Trust."

During CY 2008, 401 new Client/Family Care Plans were completed and 2,822 were updated. The initial and updated Care Plans were done to assure a continuum of comprehensive medical

care and transition to adult care when appropriate. Plans are updated when change in treatment or medical care is recommended or an additional client/family need is identified. The client/family then reviews and signs the care plan with each update and is provided with a copy for their file. Transition services also involve parents, education specialists and other interested parties. Transition screening tools for middle adolescents and young adults were completed by the client/family and used by the care coordinator in providing resources and transition services, 1,346 transition services were provided to youth, ages 14 to 21 years of age.

In reponse to the CSHCN Family Survey completed in 2006, greater emphasis was placed on the comprehensive approach to the entire family and their medical and social service needs. Educating families as to what care coordination is and how they can benefit from those services continued to be a priority in 2008. Informational material, including pamphlets and posters, were developed and distributed informing families and the public about the components of care coordination and how to access services from the CSHCN Program.

In 2008 the CSHCN provided employee in-service training to staff of the DHHR by participating in regional meetings. Emphasis was placed on care coordination and the collaboration with local health care facilities to provide nursing and social services in community clinic settings.

To support the CSHCN staff in their commitment to provide care coordination to the families they serve, a statewide staff conference was held in September 2008. Topics included an overview of the program and services offered through OMCFH as well as presentations on the ADA, IDEA, Person Centered Language and Emergency Preparedness for Children with Disabilities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with Marshall University in Parent Partners in Education (PPIE) funding results in parent advocates placed in Cabell-Huntington Hospital PICU and Pediatric Clinic.		X		
2. Parent/Professional Collaboration Conference sponsored by OMCFH and Marshall University Pediatrics.		X		
3. Survey of parents to determine priority topics of interests/concerns conducted by Center for Excellence in Developmental Disabilities through contract with OMCFH.		X		
4. Parents participate as part of the care coordination team for development of individual care plans in Part C and CSHCN Programs.		X		
5. The parent signs the Care Plan to indicate their agreement with the plan.				X
6. Copies of Care Plans and updates are shared with the child's parent.		X		
7. Care Notebook and Resource Manual were revised for distribution to families and applicants		X		
8. Paid Parent Coordinators, one in each of the 8 Birth To Three Regions are available to families, and 5 Parent Network Specialists.				X
9. All BTT participants self select practitioner offering services.		X		
10. On-going training of BTT practitioners beyond their professional licensure is required.				X

b. Current Activities

The CSHCN Medical Advisory Board met in January 2008. The membership of the Board includes the Director of Infant, Child and Adolescent Health, Director of CSHCN, the administrative team from CSHCN, and physicians that provide services in clinics and act as medical consultants for CSHCN. The Medical Advisory discussed the development of the relationship between CSHCN and community based clinics held in the tertiary care centers throughout the state. The CSHCN provides nursing and social service components of community based clinics in collaboration with CAMC and the Physician's Office Center in Morgantown.

Partnering with parents in decision making at all levels of CSHCN is demonstrated through the participation of Parent Network Specialists (PNS). The PNS system is administered by the Center For Excellence for Disabilities (CED), to ensure impartiality. PNS, in cooperation with the CSHCN Program, continued the process of updating the Care Notebooks including the resource contact section to assure clients/families receive current and accurate information to assist them in finding needed resources.

The CSC unit continues to develop and update a resource library accessible to all staff members. Included are numerous topics addressing the medical, social and educational services available to families throughout the state. The library also serves as an educational information site for enhanced skill-building.

c. Plan for the Coming Year

During FY 2008, patient/family assessments and care plans were completed or updated for all program-enrolled children through home visits, clinic visits and/or other face-to-face contacts. Priority is given to newly enrolled children and to children requiring transition services; pre- and post-surgical care; private duty and intermittent skilled nursing; nutritional assessment; child protective services; technology dependent; and those requested by physicians, clinics, other agencies. Continual emphasis will be placed on care coordination services offered through the CSHCN Program by educating participants as to services offered and the role of their Care Coordinator in providing those services.

The plans for the coming year include an all staff meeting covering important issues facing clients/families. Emphasis on care coordination and participation in the community based clinics by the CSHCN staff will be among the topics of discussion.

The Health Resources and Services Administration (HRSA), Maternal Child Health Bureau (MCHB) recently announced the awards of Family-to-Family Health Information Center (F2F HIC) grants to ten new organizations. WV was one of the ten states. As of June 1, 2009, F2F HICs will be operational in every state and the District of Columbia. F2F HICs assist families of children and youth with special health care needs/disabilities (CYSHCN) with support, information, resources, and training. Family Voices, Inc., as the National Center for Family/Professional Partnerships (NCFPP), provides technical assistance to support these activities. MCHB recently awarded a new 4-year cooperative agreement to Family Voices to continue to provide technical assistance to the F2F HICs throughout the country.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective		60	60	60	58
Annual Indicator	56.9	56.9	50.5	50.5	51.0
Numerator			35100	35100	35500
Denominator			69567	69567	69567

Data Source					CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	58	58	60	60	60

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Information about a child's primary care provider (medical home) is collected by the Systems Point of Entry Unit (SPE) during initial intake, and by CSHCN Program staff each time a child presents for service. During CY 2008, 1,551 children who received CSHCN Program services had an identified medical home. This represents 90% of children enrolled and in pending status with the CSHCN Program. SPE service coordinators link children without an identified medical home to the state's expansive network of community health centers and to primary practice clinicians for medical care. All children receiving benefits through the WV Medicaid Program, including those participating in the CSHCN Program, are assigned a primary care physician. Children, diagnosed with mental health needs, ie; socially emotionally disturbed (SED) etc., are managed by Child Protective Services and the Bureau for Behavioral Health and Health Facilities within DHHR.

Following the Public Employees' Insurance Agency's lead, WVCHIP adopted a voluntary medical home program for its members on March 1, 2007. Under this program, members agree to utilize one physician for all their primary care needs selected from a directory of qualified physicians specializing mostly in pediatric or family medicine. In exchange, co-payments for all visits to a member's designated medical home are waived. Providers receive full payment for services from WVCHIP. No formal referral process to specialists or other care outside the medical home is required by providers.

Copies of medical records, depicting care provided by CSHCN, are sent to the participating child's primary care provider to assure coordination of care.

Progress reports related to Part C/Birth To Three are also shared with the child's medical home with parental consent.

Marshall University has a medical program focusing on the needs of children who are homeless. The program provides care coordination for children staying at the Huntington City Mission and its Project Hope transitional living apartments. The effort is funded by a 5 year $250,000 Healthy Tomorrows Partnership for Children Program grant from the American Academy of Pediatrics in

cooperation with HRSA, Bureau for Maternal and Child Health. Marshall's program is the first in the state to be awarded one of these grants. The goal of the project is to provide a medical home for this unique group of children with special health care needs. The coordination of services to these families will improve children's health by decreasing hospitalizations, emergency room visits and school absences. In addition to meeting children's acute care needs, the program hopes that early identification and treatment of developmental or school problems will enable these children to become healthy, productive West Virginians. In FY 2009, OMCFH augmented the Marshall University grant by contributing $25,000.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 93% of WV children have insurance coverage		X		
2. State CSHCN Program provides extensive care coordination		X		
3. Medicaid, CHIP, PEIA and commercial carriers are requiring use of a medical home				X
4. The U.S. Scorecard ranked WV number 8 for percent of children who have a medical home			X	
5. The U.S. Scorecard ranked WV number 1 for percent of children whose personal doctor or nurse follows up after receives specialty care services				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Efforts are made to coordinate the CSHCN Program specialty care provided with the child's medical home to keep the primary care physician informed of treatment plans. The CSHCN Program strives to provide service in a manner that is accessible, family-centered, and coordinated. Care coverage is provided throughout the state in either a specialty care physician's office or at a CSHCN clinic site closest to a child's home. Medical transportation costs for appointments are reimbursed at the DHHR Medicaid established rate. The child and the principal care-givers are informed of treatment options and involved in development of the client/family care plan for the child. Care is continued until the child's 21st birthday with transition services available to prepare for independence beginning at age 14 years. Through the client/family assessment and client/family care plan development process families are linked to supportive, educational, and community-based services.

c. Plan for the Coming Year

CSHCN will continue to work with the WV Medicaid Managed Care, and other insurers to assure the needs of children with special health care needs are addressed. The planned expansion of WV Medicaid Managed Care through contracted health maintenance organizations, will have a continuing impact on the provision of care for children with special health care needs. The Medicaid Program plans that all Medicaid beneficiaries, except the SSI population and foster children, will be covered by a health maintenance organization within the year.

CSHCN will continue to work with the WV Chapter of the American Academy of Pediatrics to encourage the medical community to refer children with chronic, debilitating conditions to the CSHCN Program.

CSHCN will continue to collaborate with another office within the Bureau for Public Health, Office of Nutrition's Special Supplemental Nutrition Program for Women, Infant, Children (WIC) to assure children who are age eligible to receive WIC services are identified.

The WV Medicaid Program does not provide coverage of nutritional or feeding supplements taken by mouth. Young adults receiving such supplements, paid for by Title V, loss of funding for these medically necessary prescribed supplements when the young adult transitions from CSHCN at age 21 years often creates a hardship. The WVU Center for Excellence in Disabilities (WVUCED) nutritionist continues to work on the issue of formula needs, and OMCFH supports this effort using Title V funds.

In the coming year, the Director of the CSHCN will serve on the newly formed Emergency Medical Services for Children Advisory Committee.

The CSHCN is in the process of expanding care coordination services to a larger population of children with special health care needs in the state including those who are not enrolled in CSHCN. Efforts are underway to begin providing care coordination services in the Genetic clinics that are held in 6 cities across the State. Each of these clinics is held at least 6 times per year, and some of them are held 18 times per year. The care coordination services will be provided by CSHCN social workers who will assist children and families with resource and referral information.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		65	65	65	65
Annual Indicator	59.8	59.8	59.8	64.2	64.6
Numerator			41570	44650	44950
Denominator			69567	69567	69567
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The Systems Point of Entry (SPE) Project, housed within OMCFH, is a telephone hot-line and referral service that identifies families that do not have Medicaid, CHIP or private insurance coverage at the time an application to participate in the CSHCN Program is made. Families without resources to pay for medical services must apply for Title XIX and Title XXI, and must be denied by these sources, prior to Title V payment initiation.

During CY 2008, 89.6% of children participating in CSHCN were Medicaid beneficiaries. To assure that families have the best available coverage for their child's medical care, the CSHCN Program required all applicants to first apply for Medicaid and WVCHIP at their local Department of Health and Human Resources (DHHR) Office. Verification of their application is done through receipt of a written notice given to the family and/or by accessing RAPIDS, the Medicaid eligibility data system. Information submitted to the DHHR office during this process is also used as the determinant of a child's financial eligibility for CSHCN Program.

In 2009, $300,000 was donated by Mountain State Blue Cross/Blue Shield to purchase hearing aid services and supplies for children ages 3,4,5,or 6 years who lack insurance coverage for this benefit. This Project, administered by the Office of Maternal, Child and Family Health, Department of Health and Human Resources, is part of Governor Manchin's Kids First Initiative: Healthy and Ready to Learn.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 93% of WV children have insurance coverage (Medicaid, CHIP, Private carrier)		X		
2. CSHCN requires Medicaid and CHIP applications, to ensure Title V resources are last resort				X
3. Coordination between CSHCN and Social Security Administration facilitates access to SSI		X		
4. CHIP expanded eligibility to 240% FPL with plans for expansion to 300%FPL in yearly 20% increments				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WV CHIP, CSHCN, Birth to Three, and Right From the Start Programs continue efforts to involve the faith based community in identification and outreach to uninsured and underinsured children.

Program specialists within the EPSDT Program, continue to assure the availability of CHIP applications at all community health centers, physician offices, and local health departments, etc. This availability is monitored by the Quality Assurance Unit in OMCFH.

Patients receiving medical treatment and/or care coordination through the CSHCN Program have

their health care financed by Medicaid, CHIP, private insurance or Title V funds. Families with income of 200% of the Federal Poverty Level or below may be eligible for Title V sponsored services if they have an eligible/covered diagnosis. The Program does not have sufficient resources to act as an insurer for every chronic debilitating condition. For example, Title V does not provide payment for treatment of asthma or diabetes. Continued financial eligibility is determined on a yearly basis using a computer generated letter asking families to reapply for Medicaid and CHIP to assure Title V funds are used as payor of last resort. The care coordinator reviews financial information as well as determines continued medical eligibility.

c. Plan for the Coming Year

Building on outreach efforts for the past year, CSHCN will continue efforts to make potential recipients aware of services available through CSHCN. To expand CSHCN outreach efforts, the DHHR Division of Management Information Systems will identify approved or denied Medicaid beneficiary children (age 0-20) who have a disability. The system will generate a monthly report to use in CSHCN outreach efforts by the Systems Point of Entry unit. The SPE unit will mail identified families information about available CSHCN Program services and care coordination. This will augment population based surveillance efforts and children identified as a consequence of an EPSDT screen.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		75	75	75	90
Annual Indicator	73.1	73.1	73.1	89.7	89.9
Numerator			50850	62420	62520
Denominator			69567	69567	69567
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
In CY 2008 an informational pamphlet was given to each family at the time of enrollment. The pamphlet provided information about the CSHCN Program, eligibility criteria for continued service, services offered including aspects of care coordination and a listing of the patient/family rights and responsibilities.

Also in CY 2008 the development of Regional Specialty Care Centers (RSCC) became more of a reality when the CSHCN Program worked in collaboration with Charleston Area Medical Center (CAMC) - Women & Children's Hospital to see patients diagnosed with cystic fibrosis in their clinic setting. Medical management and genetic counseling was provided by CAMC while the CSHCN Program supplied the nursing and social service components including care coordination.

The CSHCN Program worked diligently to expand care coordination services to a larger population of children with special health care needs, including those who are not enrolled in the CSHCN Program. One of the major accomplishments in 2008 was a collaborative effort between the CSHCN and the WVU School of Medicine/Physician's Office Center. The Physician's Office Center (POC) began managing several specialty care clinics that were previously managed by the CSHCN. In assuming management of the clinics, the POC can schedule clients who are not enrolled in the CSHCN, but are in need of care coordination services. The CSHCN provides a nurse and social worker to offer care coordination services in each of these clinics, providing services to a broader population of children with special health care needs. Similar efforts are underway with Marshall University/Joan C. Edwards School of Medicine.

WV BTT received from the U.S. Department of Education the highest ranking possible for it's administration of Part C which includes evaluation of timely service delivery, parent knowledge of rights and responsibilities, parent satisfaction and measured child performance milestones. A 2007 Family-Centered Services Satisfaction Survey is included as an attachment.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Parents participate in policy and procedures development for WV Birth to Three, Hearing Screening and CSHCN.		X		
2. Collaboration with WV Medicaid to optimize resources and plan efficient use of funds.				X
3. CSHCN collaborates with other OMCFH programs to coordinate needed services efficiently.				X
4. CSHCN Medical Director participates on Medicaid policy committee sharing input from families.				X
5. CSHCN Program Advisory includes medical providers, service providers, and parents.		X		
6. Survey of BTT parents reflect satisfaction and child performance improvement.				X
7.				
8.				
9.				
10.				

b. Current Activities
The CSHCN quality assurance component was strengthened by continuation of an internal process designed to monitor staff documentation in enrolled patient records. Each month the

CSHCN Director of Nursing and the Director of Social Services review a portion of each of their assigned staff's work using an Internal Chart Review form, which identifies important elements in care management and case recording. The CSHCN Policy Coordinator also completes chart reviews on enrolled patients as well as those patients in pending status waiting to complete the enrollment process. This process identifies areas that need improvement and serves as a basis to identify staff training needs and evaluation. The system serves to augment the periodic clinic/field office site visits completed by the CSHCN Director of Nursing, the Director of Social Services and Policy Coordinator. An electronic data system was developed by OMCFH's Division of Research, Evaluation and Planning for recording and tracking of completed reviews. This allowed the CSHCN nurses and social workers to track response times from the time of inquiry, to the time of authorization and then to the delivery of patient equipment or services.

c. Plan for the Coming Year

The CSHCN Program differentiates itself from other programs/payers by continuing to emphasize the importance of care coordination services. Nurses and social workers are trained to look at the family as a whole and assess their needs, both medical and social, and link them with available resources and community services.

The Parent Network Specialist (PNS) will continue to provide resource information, support families in dealing with educational issues, and plan regional workshops to include information on transition services. The PNS will continue to develop parent support groups in their assigned areas.

The development of the Regional Specialty Care Centers continued in 2008 with the collaboration between the CSHCN Program and the Physician Office Center, West Virginia University (WVU) School of Medicine in Morgantown. The CSHCN Program provides the nursing and social service components, while the medical management of the clinic patients has been turned over to our partners at WVU. Exploring this type of collaborative effort with other medical schools in West Virginia will continue in 2009 and 2010.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective		6	6	6	41.3
Annual Indicator	5.8	5.8	41.3	41.3	41.4
Numerator			28700	28700	28800
Denominator			69567	69567	69567
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42	43	43	43	43

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Working to assure that individuals with developmental disabilities and their families have the opportunity to actually participate in the design of community-based programs and have access to community services, individualized supports, and other forms of assistance that promote and create opportunities for independence, productivity, and self-determination is a goal of the Office of Maternal, Child and Family Health.

In January 2006, the West Virginia Division of Rehabilitation Services (WVDRS) was awarded a Comprehensive Employment Systems Infrastructure Development Grant (CES-ID Grant) from the U.S. Centers for Medicare and Medicaid Services (CMS.) The CES-ID Grant was initiated collaboratively by WVDRS and the Center for Excellence in Disabilities at West Virginia University (CED) in cooperation with the Bureau for Medical Services (BMS), i.e., the state Medicaid agency within the WV Department of Health and Human Resources (DHHR). CED secured the Center for Entrepreneurial Studies and Development, Inc. (CESD) for technical assistance to develop a strategic map with the objective of describing the employment landscape for West Virginians with disabilities and identifying their needs.

Transition services are included as part of the development of the Client/Family Care Plan completed with youth enrolled in the CSHCN Program. During CY 2008, 1,346 seperate transition services were provided to youth, age 14 to 21. The Division has 47 staff who are dedicated to transition planning for children with disabilities, within the public school system.

Consistent with survey findings of the US Department of Health and Human Services, Administration on Developmental Disabilities, WV continues to recognize that knowledge of disability issues, and individuals especially those living in rural, geographically challenged areas, have barriers related to transportation and lack of quality resources.

In addition, the WV Advocates and Developmental Disabilities Council have identified the need for more integrated work/training programs for persons with disabilities. While the CSHCN Program continues to address work and training for youth transition, there is a serious gap in available employment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. CSHCN offers transition services to all program participants beginning at age 14.		X		
2. WVU Center for Excellence in Disabilities has a transition advisory.		X		
3. Marshall University School of Medicine is collaborating with Title V on transition programming.		X		
4. Participants are encouraged to access VR counseling in schools.		X		
5. WV established required certification for interpreters.				X
6. Division of Rehabilitation Services has Coorperative agreements with all 55 county school systems.				X
7. Throughout WV, 63 rehabilitation counselors are assigned to work with public and private schools.		X		
8. Rehab counselors assisted 876 students with disabilities in developing individualized plans for employment.		X		
9. Fifty-two percent of the case closures with rehabilitation services were employed.		X		
10.				

b. Current Activities

The CSHCN electronic data system produces reports identifying adolescents 14 through 21 years of age as a tracking system for social workers and nurses. These reports are produced on a monthly basis and used by CSHCN staff when determining need for frequency of contact with clients in providing transition services. Written policy concerning delivery of adolescent transition services has been reviewed and updated.

The PNS participated in community health fairs and shared medical and educational transition information with young adults and their families. They developed a Medical Transition Plan which was included in the Care Notebook distributed to each family.

School transition is an area where progress is actively occurring including: statewide and district level workshops and forums; transition targeted teleconferencing; transition assessment resource development; focus on improving achievement; attention to differences in graduation and dropout rates for students with disabilities and all students; efforts to increase collaboration and coordination with WV Division of Rehabilitative Services (DRS), Office of Maternal, Child and Family Health/Children with Special Health Care Needs (OMCFH/CSHCN) and the Department of Education (DOE); development of inclusive educational models and strategies to improve access; and, the opportunity to progress in the general education curriculum.

c. Plan for the Coming Year

The OMCFH has representation on the State Developmental Disabilities Council and shares data and programmatic information that can be used to pursue system change, increase service or support availability or otherwise promote positive and meaningful outcomes. Several examples include coordinated advocacy for the passage of an expanded newborn metabolic legislation, coordination with Vocational Rehabilitation on policy and practice to promote self-determination and transition planning for youth, and CSHCN Program staff participate in advocacy training and public policy.

A greater emphasis will be placed on transition services by collaboration between state and local school systems, Division of Rehabilitation, medical care providers, social service agencies and the CSHCN Program. Transition screening forms will be revised and updated to better determine the needs of the adolescent and their family.

While there are a number of services and programs that are designated to assist people with disabilities in various facets of training and employment assistance, central easy access to these services across agencies and providers is lacking. A forum where stakeholders can work together to bring about change is needed.

A team of stakeholders continue to assist with the core design of the strategic planning process. This team consists of representatives from: The Bureau for Medical Services, Goodwill Industries of KYOWVA, WV Developmental Disabilities Council, Workforce WV, People's Advocacy Information and Resource Services Center, Bluefield State College, Office of Special Education Assistance, WV Mental Health Planning Council, Job Accommodation Network, the CED and DRS. Technical assistance is provided by CESD and the program staff of CED.

Varieties of assessments across different groups continue to be completed. The voices heard within the state from a wide audience (education, business, advocates and people with disabilities and their families) provides positives, challenges and ideas for improvement.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	85	95	95	95
Annual Indicator	93.5	93.5	90.3	93.3	93.1
Numerator	58000	58000	56000	57850	57710
Denominator	62000	62000	62000	62000	62000
Data Source					2008 Immunization Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	96	96	96	96

Notes - 2008
WV Immunization Program 2008...numbers were provided for individual immunizations (DTaP-4: 86%, IPV-3: 93.8%, MMR-1: 94.2%, Hib-3: 96.1%, Hep B-3: 95.5%)...numbers were added together and divided by total number for overall percentage

Notes - 2007
WV Immunization Program 2007...numbers were provided for individual immunizations (DTaP: 86.2%, Polio: 94.5%, MMR: 95.1%, Hib: 96.1%, Hep B: 94.7%)...numbers were added together and divided by total number for overall percentage

Notes - 2006

WV Immunization Program as of June 2006...numbers were provided for individual immunizations...numbers were added together and divided by total number for percentage

a. Last Year's Accomplishments

The State's Division of Immunization Services is housed in the Office of Surveillance and Disease Control, Bureau for Public Health. This division works closely with local health departments, WIC, hospitals, the private practicing medical community, and early childhood programs in an effort to get children fully immunized. Immunization data for 2008: 86% had been immunized for DTaP-4, 93.8% for IPV-3, 94.2% for MMR-1, 96.1% for Hib-3 and 95.5% for Hep B-3. All of these individual vaccines have risen since 2005. The state Division of Immunization Services and the statewide immunization coalition, West Virginia Immunization Network (WIN) have collaborated to implement the "Take Your Best Shot" campaign targeting adolescents for HPV, MCV, Tdap, chickenpox and Hep b vaccinations in sixteen counties, up from 7 counties in 2008. WVCHIP provided matching funds to Raleigh County to implement the "Take Your Best Shot" adolescent campaign, which began in October 2007. The Immunization Program worked with the WV Higher Education Policy Commission to develop a list of recommended immunizations for college enterers. WVCHIP materials were included in the State's Immunization Program packets to new mothers through the Right From The Start Coordinators.

The EPSDT Program has actively worked to ensure that children participating in the program receive complete immunizations by age 2. The HealthCheck program publicizes the Childhood Immunization Schedule in a HealthCheck Provider Manual that is used by approximately 1,200 HealthCheck providers. The providers immunize children in accordance with the schedule or they refer their clients for immunizations in accordance with the schedule to alternate pre-arranged referral sites in the community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In 2008, WV was 17th in the nation for completion of regularly scheduled immunizations on children between 24-35 months of age.		X		
2. The EPSDT/HealthCheck Program encourages providers to offer immunizations as part of health care.				X
3. The RFTS Project collects data on whether or not infant participants (who are up to 12 months) are up to date on immunizations.				X
4. All women giving birth in WV receive an information packet including an immunizations schedule before leaving the birthing facility.		X		
5. WV does not allow non-medical exemptions for immunizations.				X
6. Partnered with West Virginia's Immunization Network(WIN) to promote adolescent immunizations.		X		
7. Need for imunizations is promoted by RFTS, WIC and other public health programs.		X		
8.				
9.				
10.				

b. Current Activities

The West Virginia Immunization Program is working to increase the number of providers who regularly report to the immunization registry, the West Virginia Statewide Immunization Information System (WVSIIS). Of the 390 providers of immunizations enrolled in the Vaccines for

Children (VFC) Program, all have reported at least once to WVSIIS, but only 80-85% report regularly. A certificate of immunizations has been developed. The Certificate of Immunization will help improve preschool and school-age immunization levels by establishing a standard process by which children are given documents certifying receipt of age-appropriate immunizations. A uniform Certificate of Immunization will enable the consolidation of all valid immunization dates on one document that can be utilized by schools, child care centers and in other settings. The certificate is a tool used by the Immunization Program as an ongoing effort to increase preschool and school immunization levels in West Virginia. VFC Providers in WV may now order vaccines online via the WVSIIS. Additionally, providers may manage inventory and generate vaccine usage reports, coverage rates, and reminder/recall messages from the registry. The WVSIIS has also developed a consent authorization form for public schools to distribute to guardians of new school enterers in the K-12 school system which would authorize the Department of Education to share the immunization records of new school enterers with the WVSIIS database.

c. Plan for the Coming Year

The Office of Maternal, Child and Family Health's responsibility is one of tracking and increasing medical capacity to serve as health homes for children. The Immunization Program interfaces with the Office of Maternal, Child and Family Health in developing public health policy. The OMCFH workforce that provides technical assistance to the medical community on all child health issues also provides guidance on vaccine administration.

The OMCFH maintains a Pediatric Medical Advisory comprised of pediatricians, family practice physicians, dentists, etc. who assist with policy guidance but also serve as spokespersons offering guidance for public health policy. Persons serving in this capacity speak routinely at the West Virginia Chapter of the AAP and AAFP. Using these champions to voice public policy about immunizations and other child health issues assists the Department with compliance and keeps the medical community engaged in the provision of service.

EPSDT/HealthCheck will be sending parents of non-HMO Medicaid eligibles with children ages 11-19 materials about the importance of adolescent immunization.

The West Virginia Immunization Network, the State's Immunization Program and WVCHIP continue working on strategies to implement an immunization campaign targeting adolescents.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	20	19	19	19	19
Annual Indicator	20.1	20.0	20.9	20.7	19.8
Numerator	712	707	739	733	700
Denominator	35411	35411	35411	35411	35411
Data Source					2007 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	19	18	18	18	18

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Statistics

a. Last Year's Accomplishments
The Adolescent Pregnancy Prevention Initiative, housed with OMCFH within the Division of Perinatal and Women's Health, collaborates with other agencies to build community partnerships allowing APPI to observe and evaluate the needs of those we serve. As we work together on local, state and national levels, we continue to include and involve the opinions and ideas of our teens. Young minds offer us insight as we plan awareness activities that offer them not only information but real life alternatives. A list of activities included:
•369 school presentations, addressing student populations on the topic of teen pregnancy prevention/sexually transmitted infections
•138 school visits which introduced Adolescent Pregnancy Prevention Initiative and the APPI Specialists for that region
•5 presentations to County Boards of Education
•327 informational packets were mailed to West Virginia High/Middle Schools statewide
•APPI displayed at 39 community events statewide
•7 college/university campus visited statewide
•4 presentations at Juvenile Detention Centers statewide
•1 Housing Authority presentation
•9 Family Planning Program sites visited by APPI Staff
•4 presentations at 3 Alternative Learning Centers
•1 Live Radio broadcast promoting National Day Campaign
•Processed 43 requests for educational resources
•During classroom presentations additional educational materials were distributed

April is "Picture Your Future Campaign"
Prom season kicks off APPI's "Picture Your Future Campaign". West Virginia high schools participate by conducting a pregnancy prevention activity. Activities may include lunch and learn, public service announcements, and/or a bulletin board informational activity. Picture frames were presented to each student that attended prom. Picture frames are an incentive to encourage teens to make responsible choices that will impact their future by "picturing their futures".

National Teen Pregnancy Prevention Month
The purpose of "National Day" is to help teens understand pregnancy can happen to them and they need to think seriously about what they will do to prevent it. On National Day, teens are asked to log on the National Campaign to Prevent Teen Pregnancy's web site (www.teenpregnancy.org) to take an on line quiz that highlights key issues, feelings, and beliefs about teen pregnancy through a series of real life scenarios. The National Campaign also offered National Day Quiz discussion guides for parents and teens which were downloaded in the thousands.

October is "Let's Talk Month"
This is a way for parents and educators to discuss prevention of teen risks behaviors in a proactive, constructive manner. "Let's Talk Month" offers bookmarks, fact sheets, and brochures to all middle and senior high schools, Family Planning Program providers and others interested in

promoting improved parent-child communication. Letters were mailed to all public libraries with informational materials related to "Let's Talk Month".

CHIP refers teen-age participants to Family Planning so that they can have confidential safeguards under Title X. In 2007, 15,060 teen-age females and 748 teen-age males received family planning services.

There is an attachment that talks about teen-age pregnancy in WV.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adolescent Pregnancy Prevention Specialist conducted numerous community education and outreach activities on a regional/local level.		X		
2. Conducted 369 school presentations at WV schools and 39 community events.		X		
3. Recognized and promoted "National Teen Pregnancy Prevention Month".			X	
4. Recognized and promoted “Let’s Talk Month”.			X	
5. Recognized and promoted “Picture Your Future Campaign”.			X	
6. Free family planning services are available at 153 locations		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Abstinence Education Program (AEP) funds five regional abstinence programs to provide abstinence education services in nineteen WV counties. The AEP works collaboratively with county boards of education to implement a comprehensive approach including a five to eight week curriculum program, extracurricular activities, community-based events, and parental involvement.

The AEP and AHI formed a community-based coalition titled "THINK", which stands for Teaching Health Instead of Nagging Kids. THINK is a multi-disciplinary coalition that came together in an application for community-based abstinence funding as part of a state-wide plan to expand abstinence education in WV. This collaboration has expanded abstinence education to twenty-nine WV counties, an increase from seventeen counties served in 2006.

APPI goals/objectives are carried out by 5 full time personnel who are hired to conduct statewide community education and outreach activities on a regional/local level. The specialists are strategically located in community-based settings to have the flexibility of alignment as needs change. The specialists work to increase community awareness of problems associated with risky behaviors. The specialists develop and maintain a statewide network of individuals which impact the issues of adolescent pregnancy prevention; risky sexual activities, decision making and risk reduction by providing community education and outreach activities to teachers and peer leaders.

c. Plan for the Coming Year

APPI will continue to provide development, oversight and coordination of educational activities within regional/local communities. An APPI Specialist will incorporate multiple teaching methods and personalize to individual needs. The APPI will continue to conduct community education and outreach activities to increase public awareness of adolescent pregnancy prevention and related issues targeting community groups, schools, health care professionals, and parent groups.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	50	33	35	38	30
Annual Indicator	30.0	33.3	37.5	55.9	56.1
Numerator	1039	1416	1309	11461	11500
Denominator	3466	4256	3488	20485	20485
Data Source					Health Care Authority
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	57	57	58	58	59

Notes - 2008
Previous years not calculated or reported correctly.
Based upon 2006 data from Health Care Authority with Medicaid children with procedure code of D1351 (sealant) by age group.
Denominator from Vital Statistics and US Census.

Notes - 2007
Previous years not calculated or reported correctly.
Based upon 2006 data from Health Care Authority with Medicaid children with procedure code of D1351 (sealant) by age group.
Denominator from Vital Statistics and US Census.

Notes - 2006
The Children's Dentistry Project covers 45 of WV's 55 counties and is being used as representative for the state's 3rd graders.

a. Last Year's Accomplishments
The CDP, in partnership with county school systems, Head Start agencies, WIC, 4-H, and other community children's programs, are working together to offer a sealant and fluoride rinse program within schools. Payments from existing insurance sources are sufficient to cover operational costs and ultimately improve oral health access. This project was initially provided only to students in Lincoln County but the OHP is working to expand this service to students in Mason and Mingo Counties.

The OHP has provided portable dental equipment to primary care facilities for the purpose of offering school-based dental services in Calhoun, Fayette, Jackson, Lincoln, Marshall, Nicholas, Ohio and Ritchie Counties to include sealant applications.

During an advisory board meeting in November 2008, it was reported that 53% of children have coverage with Medicaid or CHIP and there are 859 licensed practicing dentists in WV with over 500 serving Medicaid and CHIP patients. Sealants are a covered benefit for Medicaid and CHIP beneficiaries.

Every county in WV has a dentist who accepts Medicaid and/or CHIP. There were 61,649 children who received oral health education and promotion in 2008 in West Virginia. WV serves 21,855 children with dental screenings, 16,328 in the fluoride rinse program, 397 in the fluoride supplement program, 16,376 in the mouth guard/injury prevention program, and 95 children served in the sealant program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Children's Dentistry Project (CDP) subgrants preventive health block funds for application of sealants.		X		
2. CDP collaborated with a CHC and a county school system on a pilot project for sealant application.		X		
3. CDP provides oral health education which includes information on sealants.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program works in concert with other OMCFH programs, Head Start, and the public school system to promote awareness and availability of oral health services as an integral part of preventive, primary health services through educational instruction. Oral Health efforts are funded from the Preventive Health Block grant, Title V, and State appropriation. The Program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children and adolescents which encourage behavioral change; i.e. regular check-ups, brushing/flossing, use of mouth guards during sports activities, and healthy lifestyles through being drug, alcohol, and tobacco free. OMCFH has contracts with local health departments, primary care facilities, and oral health care professionals to provide educational services and materials to all 55 counties in West Virginia. These local health departments and contracted dental hygienists are responsible for oral health education efforts which include working with the public school system. The Office has developed education modules which were approved by the WV Dental Association, and utilizes oral health supplies and educational materials that are used in public school instruction. This program also supports fluoridation and sealant efforts in the community, in addition to providing oral health supplies and education materials which are requested from and sent to various partners throughout the state.

c. Plan for the Coming Year
The CDP continues to work in conjunction with Valley Health Systems to provide sealants to elementary students in Lincoln County. Plans are being discussed to expand these services to Mason, Jackson and Mingo Counties for the 2009-2010 school year.

The CDP Coordinator will work closely with the Early Childcare Services Coordinator to learn more about what can be done to improve dental health services for WV children.

The CDP will assist two community water systems in obtaining fluoridation equipment in 2009. The Office of Environmental Health Services has been approached as a non-funding partner and is willing to participate. Other funding sources are currently being explored. The infrastructure development will have lasting implications and may be supported through the Governor's Office of Community Development.

OMCFH has been charged with convening an expanded Oral Health Advisory to study policy and processes necessary to improve oral health access and utilization in West Virginia. This charge by the Legislature is complicated by the fact that the assignment is population-based, and so many West Virginia adults (and some children) lack access to dental health service financing/insurance. For example, West Virginia Medicaid does not provide dental coverage to adult beneficiaries except to alleviate pain and suffering, i.e., extraction. There is no special coverage extended to pregnant Medicaid beneficiaries, although there has been discussion around pregnancy, periodontal disease and preterm labor. WV Medicaid and WVCHIP provides dental coverage to children beneficiaries.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.5	3.5	3	3.3	3.9
Annual Indicator	6.1	3.6	4.6	5.4	4.7
Numerator	20	12	15	17	15
Denominator	329137	329137	329137	316809	316809
Data Source					2007 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.5	4.5	4.5	4	4

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Stats

a. Last Year's Accomplishments
Traffic fatalities for all West Virginia's have dropped from 431 deaths in 2007 to 378 in 2008, based on data collected by highway officials. Police departments have significantly stepped up efforts to crack down on aggressive and drunken driving in the past few years. The police departments credit most of its success to high visibility enforcement and their media messages. They noted the flurry of seatbelt and anti-drunken driving commercials that air throughout the day. The Click It or Ticket campaign has been especially effective relying heavily on targeted advertising aimed at getting teens and young adults to use their seat belts. Law enforcement efforts to deter drunken drivers also play a significant factor. West Virginia holds more sobriety checkpoints per capita than any other state.

In 2007, of the 76 young persons ages 0-21 killed in crashes, 41 did not use any occupant protection and 10 were unknown. Only 25 were using any type of protection such as a lap and shoulder belt, child safety seat, motorcycle helmet, etc. In 2008, of the 59 young persons ages 0-21 killed in crashes, 25 did not use any occupant protection and 7 were unknown. Twenty-seven persons who died were using some type of occupant protection.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Department of Education/Health Education Assessment Project to calculate student health knowledge of seat belts and other safety issues.		X		
2. Adolescent Health Coordinators and others provide classroom injury prevention instruction.		X		
3. The EPSDT Program provides anticipatory guidance to parents regarding childhood injuries.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Initiative offers parent/child communication skill building, community development activities that include plans for safe recreation after prom, etc. Helping families to talk with their children about risk behaviors is an essential part of affecting change.

The EPSDT Program continues to provide anticipatory guidance to parents about childhood injury that may result in death. The Adolescent Health Initiative also develops teaching tools which encourage the use of helmets as a means of preventing traumatic brain injury. At the time of discharge, all birthing hospitals in the State issue an infant car seat for those families who do not have/can't afford one. The Adolescent Health Initiative was designed to complement the HealthCheck Program with the express purpose of creating awareness among families and others of the need for young persons between the ages of 10 and 17 to be provided routine health services. This program includes: 1) the provision of educational programs emphasizing

preventive services/risk reduction behaviors such as seat belt use and tobacco/alcohol use; and 2) development of teaching modules that can be used in community-based training designed to improve the health and well-being of adolescents and their families.

c. Plan for the Coming Year
Work continues with the Transportation and Traffic Safety Division to develop materials that are directed to youth. We also use our existing workforce and partnership network for distribution of this anticipatory guidance.

Partnerships continue to support the Department of Education efforts to improve health education instruction in public schools designed to positively affect health and health related decision making.

The Division of Highways will lead the development of implementation plans to execute the initiatives in the Strategic Highway Safety Plan. While extenisve work is currently underway to implement many initiatives outlined in the Plan, a coordinated effort continues to devise both emphasis area implementation plans and an overall detailed management plan for the Strategic Highway Safety Plan.

To be effective, a plan cannot rest upon a shelf. It must be refined over time to address changing conditions. The Strategic Highway Safety Plan is viewed as a dynamic document and will continue to evolve as West Virgina evaluates its outcomes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			35	35	60
Annual Indicator		32.0	56.0	32.5	33.9
Numerator		6700	11730	7155	7500
Denominator		20920	20931	22017	22100
Data Source					2007 PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	35	35	40	40

Notes - 2008
based upon 2007 PRAMS data - mom breastfeeding at 8 weeks

The Annual performance objective should be 35 and not 60

Notes - 2007
2007 PRAMS data - mom breastfeeding at 8 weeks

Notes - 2006
PRAMS data - mothers who initiated and breastfed for any period of time

a. Last Year's Accomplishments
While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the RFTS Project receive information about the benefits of breastfeeding their infants. RFTS Project care coordinators provide comprehensive in-home breastfeeding education and support to prenatal participants through sixty days postpartum and to breastfeeding mothers of eligible infants until their infant reaches age one year. Educational tools such as videos, DVDs, brochures, a pregnancy workshop and medical models are available to RFTS care coordinators for use on home visits to promote breastfeeding. A DVD player has been provided to each RFTS care coordinator in order to more effectively provide client education in their homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Display booth at the West Virginia State Fair sponsored by WIC.		X		
2. The WIC Program strongly supports and promotes breastfeeding.		X		
3. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians practices in order to keep mothers breastfeeding longer.				X
4. WIC increased income guidelines to allow more women, infants and children to qualify.				X
5. RFTS collects data on prenatals who are breastfeeding at hospital discharge, and how many continue to breastfeed at case closure.				X
6. All women participants in the RFTS receive benefits of breastfeeding information.		X		
7.				
8.				
9.				
10.				

b. Current Activities
According to WIC, West Virginia peer counseling funds of $90,092 will be distributed to local WIC agencies to supplement breastfeeding peer counselor salaries and benefits. One breastfeeding goal is to provide additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians practices in order to keep mothers breastfeeding longer. Focus on breastfeeding is a preventative step in helping reduce childhood obesity.

Pregnant RFTS Project participants are encouraged to breastfeed and receive education on health and socioeconomic benefits, i.e; how human milk meets the specific needs of human babies and changes with growth to offer the best combination of nutrients.

c. Plan for the Coming Year

The RFTS Project will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for care coordinators to use during home visits. RFTS care coordinators promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train the coordinators on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their choice for infant feeding.

Women can be encouraged to breastfeed longer into the postpartum period by being educated to seek assistance from local support groups, other mothers who have successfully breastfed and from their local WIC lactation consultants.

The Director of Perinatal Programs and the RFTS regional coordinators will continue collaborative efforts with staff of the WV Office of Nutrition Services to ensure that local WIC offices refer clients to the RFTS Project and work effectively with the regional coordinators.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98.5	99	99	99
Annual Indicator	90.2	93.7	91.9	94.7	95.0
Numerator	18868	19526	19431	20843	21000
Denominator	20911	20834	21137	22017	22100
Data Source					Birth Score Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
based upon 2007 WVU Birth Score Data - infants screened before hospital discharge

Notes - 2007
2007 WVU Birth Score Data - infants screened before hospital discharge

Notes - 2006
2006 WVU Birth Score Data - infants screened before hospital discharge

a. Last Year's Accomplishments
In 2007, additional improvements in the database allowed for more enhanced data collection by linking newborn hearing screening follow-up data collected by the Project (NHS) and the Birth Score. This was an important step in improving the data system and identifying issues needing attention. In 2008, time was dedicated to cleaning the database with the goal of timely identification of the need for follow-up.

Interlacing Birth Score and NHS follow-up information has significantly reduced the risk of human

error as well as time involved in completing forms with duplicate information. The BSO, NHS and Vital Statistics staff continued to discuss the BSO receiving timely current birth information to identify those infants for whom a Birth Score card had not been completed, and identify hearing screen data.

The entire referral and follow-up process has been streamlined and allows the database to serve as a monitoring tool for quick reporting on specific practitioner performances. This helps assure project protocols are completed, as well as provides information to the NHS Project.

West Virginia birthing facilities continue to be concerned with the number of newborn hearing screens and Birth Score cards not being completed before discharge and provide opportunities to screen infants who are missed after discharge. Equipment failure at birthing facilities is a common reason cited for missed screens and prompted the use of NHS Project money to purchase loaner equipment. Loaner machines have been used in several instances throughout the year, helping to continue hearing screening before discharge and reduce the number of referrals made to RFTS for follow-up.

To help reduce the number of lost referrals in 2008, Designated Care Coordinators (DCCs) who are licensed nurses or social workers in RFTS provider agencies, sent an introductory letter and brochures discussing the need for hearing follow-up services, and other health/social service offerings, when initial phone contact cannot be made.

Four regional trainings held statewide helped to update RFTS staff on Newborn Hearing Screening policies, procedures and other relevant information. One hundred twenty-five participants traveled to the four sessions and evaluations showed that, overall, seventy-three percent (73%) of the participants found the sessions to be excellent.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All WV birthing facilities are required to screen infants for hearing loss before discharge.			X	
2. Infants identified with a hearing loss are referred to the CSHCN Program for assistive devices		X		
3. OMCFH purchased and maintains diagnostic equipment to assure access/availability as loaner equipment and shared hospital equipment.				X
4. Redesigned and updated NHS website.				X
5. Educational literature is created and distributed to providers and parents.		X		
6. Maintain Advisory Board members per WV state code.				X
7. A $300,000 grant was secured from Blue Cross/Blue Shield to provide hearing aids for children under the age of six who do not have insurance that will cover the aids.				
8.				
9.				
10.				

b. Current Activities

The NHS Project continues to focus on improving access to timely audiological diagnosis and intervention. Birthing hospitals continue to be provided with NHS information and education from the Birth Score Office. Audiological service availability and resource guides are disseminated to providers, audiologists and community agencies by the NHS Project in order to assure that

infants and their families are directed to appropriate hearing evaluation and intervention as quickly as possible and informational brochures in both English and Spanish, continue to be distributed through community health fairs and other events statewide.

Continued efforts are being aimed at cleaning the database and outlining processes, as well as improving database usefulness as an oversight tool to provide the most current, detailed information to regional staff for the timeliest follow up for infants and their families.

The eight region Right From The Start workforce continues to follow-up with families of infants who initially missed or failed screens, through direct referral from the Birth Score Office. In May, a two day workshop was held in Charleston for RFTS covering many topics relevant to interviewing clients, engaging clients in providing services and documenting progress reporting.

An Advisory meeting will be held in Sept, 2009 to obtain input to improve follow-up and screening processes for the NHS Project.

c. Plan for the Coming Year

Goal 1: Screen 100% of newborns prior to discharge or within the first month of age, minimizing missed infants and decreasing rates of cases referred to RFTS for follow up services as well as lost to follow up services.
Objective 1: Assure all 34 birthing facilities have two trained staff competent in screening and referral protocols and loaner equipment available in case of equipment failure.
Objective 2: Assure a minimum of 90% of resident infants born in hospitals bordering WV continue to be tracked via the Birth Score System and Vital Statistics and/or data sharing agreements and referred for services when indicated.
Objective 3: Assure WV resident infants born at home will receive follow up for screening.

Goal 2: 100% of infants requiring audiological follow up and/or intervention receive a diagnostic evaluation by 3 months of age and intervention services by 6 months of age.
Objective 1: Assure a minimum of 80% of all PCP/Medical Home from each of 8 service regions are knowledgeable about follow up and intervention resources.
Objective 2: Improve NHSP follow up to assure appropriate, timely audiological evaluation and intervention by having hospital staff verify contact information and getting a second contact for families prior to discharge.

Goal 3: 100% of infants referred for screening receive follow up and audiological evaluation by a qualified provider.
Objective 1: Assure one audiologist in each of the 8 service regions is trained to provide diagnostic follow up and select/fit appropriate amplification.
Objective 2: Identify and recruit additional medical providers to improve the availability of diagnostic testing for infants who fail initial screens.
Objective 3: Explore/discuss with Advisory Committee the option of purchasing additional hand held OAE hearing screen equipment to be used in a pilot region for home visit follow up screens or scheduled follow up screens at a regional location convenient for families. Train an RN in the pilot region to perform hearing screens for referred infants.

Goal 4: Continue to assess resources to assure 100% of children with hearing loss and their families are linked to community-based, culturally competent support systems.
Objective 1: Maintain a training level of at least 90% of the early intervention specialists and coordinators to address intervention for children with hearing loss. (Part C-BTT)
Objective 2: Parent information, letters, brochures and resource guides will be updated/created in English and Spanish.
Objective 3: Assure 100% of children with hearing loss and their families be referred for early intervention.

Objective 4: The web-based resource directory will be updated annually.

Goal 5: Continue to provide monitoring, evaluation and quality assurance reports.
Objective 1: Produce quality, comprehensive data reports and conduct program monitoring and evaluation quarterly and annually.
Objective 2: Continue data linking efforts enabling individual tracking and follow-up.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5	5	4	5.7	4.3
Annual Indicator	5.6	5.8	5.7	4.5	4.5
Numerator	24025	24664	24500	19057	19057
Denominator	427879	427879	427879	427879	427879
Data Source					2008 CHIP Annual Report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.2	4	4	3.5	3.5

Notes - 2008
2008 CHIP Annual Report - data for fiscal year ended June 30, 2008

Notes - 2007
2007 CHIP Annual Report - data for fiscal year ended June 30, 2007

a. Last Year's Accomplishments
During the 2006 Legislative session, House Bill 4021 passed authorizing WVCHIP to adopt a higher income limit of 300% for program eligibility. In implementing this legislation, the Board adopted premium payments for those children with family incomes above 200%FPL. The Bill also extended the "waiting period" for children to be uninsured, from the six-month requirement for the regular WVCHIP program, to twelve months for children eligible under the expanded program. After much deliberation, the Board, at the request of the Governor, adopted a higher income limit of 220%, with planned annual expansions in 20% increments, until the full 300% limit is adopted. On January 1, 2007, WVCHIP implemented the higher income limit for program eligibility of 220%FPL. This expanded program was named WVCHIP Premium. In addition, the Board approved a full medical and drug benefit package, with higher co-payments, a limited dental package, and no vision coverage.

Following the Public Employees' Insurance Agency's lead, WVCHIP adopted a voluntary medical home program for its members on March 1, 2007. Under this program, members agree to utilize one physician for all their primary care needs selected from a directory of qualified physicians specializing mostly in pediatric or family medicine. In exchange, co-payments for all visits to a

member's designated medical home are waived. Providers receive full payment for services from WVCHIP.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State leaders promote SCHIP and increasing enrollment.				X
2. Currently WVCHIPs elgibility is 220%FPL. This will increase by 20% a year until 300% is achieved.		X		X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Governor Manchin charged an interdepartmental team with working on a goal of assuring that every child starts school healthy and ready to learn. In an initiative called Kids First, the strategy to reach this goal is to assure that every child has an opportunity for a comprehensive wellness exam by a physician prior to entering kindergarten. WVCHIP played a key part in this iniative seeking approval of State Plan changes that would permit the program to reimburse providers rendering wellness exams to uninsured children as a special public health or preventive measure. Since West Virginia now has health coverage in a public or private form for 97% of its children, federal approval would mean that the remaining 3% with no insurance (or about 1,100 children of kindergarten age) could receive such a wellness exam.

The Director of the WVOMCFH has been an active member of the Governor's planning committee for the Kids First Initiative.

CHIP has partnered with clinics across the state encouraging them to distribute applications for CHIP. The WV Primary Care Association received fiscal support to provide community-based outreach for CHIP statewide.

The Pediatric Program Specialist, as a part of EPSDT, administered by OMCFH, routinely distributes CHIP applications when visiting medical practioner sites serving children.

Medicaid has no plans for eligibility expansions so SCHIP is the sole source available for financing health care for medically indigent WV children.

c. Plan for the Coming Year

West Virginia has become one of the most successful states in enrolling children in CHIP and Medicaid. More than 97% of the state's children now have health coverage. The increase in enrollment of children in both CHIP and Medicaid has been the result, in part, of the efforts of a public/private partnership between the WV Healthy Kids Coalition, primary care centers, Family Resource Networks, state government, and private and public funds. For the last four years, the WV Healthy Kids Coalition has conducted community-based outreach for CHIP and Medicaid through the placement of outreach coordinators who serve each of the state's 55 counties from 49 locations. Since the inception of this program, more than 40,000 children have been enrolled in CHIP and more than 5,000 children have been enrolled in Medicaid via the CHIP application.

To maintain and even improve upon this high level of enrollment we must continue this effective outreach and enrollment effort and explore the recommendations from advocate group for affordable health coverage.

Given the above, our issues are assuring that the state has sufficient medical capacity to meet the demand and secondly, creating a demand for care by educating would-be consumers on the importance of receiving basic primary, preventive health care. In order to determine why patients aren't using the health services now that they have health care financing, we plan to survey families and providers about issues of accessing care.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	24	23
Annual Indicator		27.2	25.0	24.0	27.4
Numerator		6488	5899	4938	5169
Denominator		23861	23611	20556	18835
Data Source					2008 WIC Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	25	25	25	25

Notes - 2008
2008 WIC data

Notes - 2007
2007 WIC data

Notes - 2006
2006 WIC data

a. Last Year's Accomplishments
According to 2008 WIC statistics, 27.4% of children ages 2 to 4 receiving WIC services, have a BMI at or above the 85th percentile. This was up from 2007 when it was 24%.

Because obesity among WV children contines to be a problem, the EPSDT/Healthcheck screening form, used for all kids under the Kids First initiative and for all Medicaid cardholders, has been modified to include BMI. Further, the WV Cardiac Project has screened more than 60,000 kids for cardiovascular risk factors over the past ten years. Findings suggest that one third of kindergarten and second graders and 47% of fifth graders are overweight on the BMI assessment.

While addressing childhood obesity is not an easy task, the reach and focus of the WIC Program offers a unique opportunity to reduce and prevent this problem, starting with promotion and support of breastfeeding. (See earlier report on breastfeeding).

Eligible WIC recipients are issued Farmers Market Nutritional Program coupons in addition to their regular WIC food instruments. These coupons can be used to buy fresh, unprepared fruits, vegetables and herbs from farmers or farmers' markets that have been approved by the State agency to accept FMNP coupons. The Farmer's Market Nutrition Program has continued to grow through the WIC Program with 52 counties participating through 33 WIC sites. Redemption rates grew to 70% in 2008.

WIC Notes is a quarterly newsletter published by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Nutrition Services. The winter 2008 publication highlighted adults as role models and had a target article entitled: Kids copy adults, so eat healthy and be active every day!

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), recently expanded eligibility to the program with significant increases in the income guidelines. A family of two may now make up to $26,955 a year and be considered eligible for WIC services; for other household sizes, add $6,919 for each additional family member. This eligibility expansion will allow more pregnant, breastfeeding and postpartum women to take advantage of the program as well as infants and children up to age 5. Families can purchase healthy food stuffs including milk, eggs, dried beans, peanut butter, natural cheese, iron fortified cereals and infant formula, as well as Vitamin C-rich natural juices. Furthermore, effective October 1, 2009, WIC will begin offering infant foods, whole grain breads, soy-based beverages, canned beans and fresh fruits and vegetables.

All local WIC agencies are engaged in grassroots marketing and complete at least 102 hours of outreach in their local communities. This has resulted in increased program access with 4.40% statewide caseload growth through 2008. The WIC Program served an average of 51,770 people each month and contributed $38.6 million to the WV economy through food purchases. WIC has had a statewide caseload growth of 2.18% thus far in FY 2009.

Be Healthy, a web-based instructional model that focuses on weight management, cardio health, and physical activity is available in all WV schools.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC supports healthy nutrition and breastfeeding.	X			
2. WIC increased income guidelines to allow more women, infants and children to qualify.				X
3. 23% of the WIC Budget is dedicated to nutrional education.		X		
4. Cardiac Project is operational		X		
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The West Virginia WIC Program has developed and implemented online nutrition education to address access barriers and transportation difficulties. The purpose of the website is to help WIC participants learn more about feeding their child such as providing regular meals and snacks, working with picky eaters, creating a positive eating environment, and the roles of the parent and the child in the feeding relationship. WIC participants explore these pages and complete an easy to read module for a "Certificate of Completion." This certificate can be taken, emailed or mailed to the local WIC clinic to get "credit" for nutrition education needed to obtain food vouchers.

c. Plan for the Coming Year
Addressing obesity and overweight in the child populations will continue and the focus remains on increasing initiation and duration of breastfeeding, promotion of increasing consumption of fruits and vegetables, increasing physical activity and the use of lower fat milk in women and children over 2 years. This will continue to be done with parents in individual counseling and nutrition education classes.

WIC participants receive individual and group nutrition education, breastfeeding support, referrals to health care providers, assistance with making healthy lifestyle choices, and help with immunizations. The Special Supplemental Nutrition Program for Women, Infants and Children provide participants with certain healthy foods for free, and offer assistance in planning low-cost healthy meals that include foods high in essential nutrients and vitamins.

The WV WIC Program will continue the Pick a Better Snack campaign in conjunction with the State Nutrition Network. Pick a Better Snack promotion will occur through radio spots, material distribution in WIC clinics, and public relations events during National Farmer's Market Week.

Implementation of the new WIC food packages will continue to present opportunities to reinforce nutrition messages, provide breastfeeding incentives and further supplement the diets of medically fragile participants. The branding and phases in the process are geared towards the vision of improving the long-term quality of life for West Virginia families through healthy lifestyle choices in coordination with participation education and community partnerships.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	27	26
Annual Indicator		25.3	29.0	30.0	27.1
Numerator		5225	6075	6595	6000
Denominator		20630	20931	22017	22100
Data Source					2006 PRAMS
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26	25	25	25	25

Notes - 2008
based upon 2007 PRAMS data

Notes - 2007
2007 PRAMS data

Notes - 2006
2006 PRAMS data

a. Last Year's Accomplishments
West Virginia has the third highest adult smoking rate in the U.S. at 26.7%, the highest percentage of women smoking during pregnancy and the highest rate of spit tobacco use among men at 15.9%.

The percentage of smoking during pregnancy is not declining despite all of the efforts targeting this important health issue. Tobacco is clearly a problem for our state.

The West Virginia Division of Tobacco Prevention (DTP) is one of four divisions within the Office of Epidemiology and Health Promotion. The WVDTP funds prevention activities through its three programs - Youth Prevention, Clean Indoor Air and Cessation.

The 2007 PRAMS data indicates that 30% of women were smoking while pregnant in West Virginia. In an effort to address this crisis, the Tobacco Cessation Program funds several projects. The Tobacco Free for Baby and Me Program administered by CAMC-Women's and Children's Hospital is now in its second year of providing tobacco cessation counseling through its high-risk OB clinic. The DHHR Office of Maternal Child and Family Health offers tobacco counseling during in-home visits through the Right from the Start (RFTS) network, the state's perinatal program. The Day One Project offered by the WV Hospital Association is providing education on the dangers of second-hand smoke to new mothers and their families after the child is born. The Women, Infants and Children (WIC) Office of Nutrition Services partners with DTP to distribute educational materials to those women who receive services through 55 clinics throughout WV.

The purpose of the tobacco free pregnancy initiative is to educate women of child-bearing age as well as those who are pregnant on the dangers of using tobacco and to educate every healthcare provider on the urgent need for face-to-face tobacco cessation counseling.

Pregnant RFTS clients have a high incidence of smoking during pregnancy. According to 2007 data collected by the Project 42% of pregnant participants were self reported smokers. In response WV continued to provide an intense smoking cessation initiative, The WV RFTS SCRIPT (Smoking Cessation/Reduction in Pregnancy Treatment), implemented statewide in 2002 through the Office of Maternal, Child, and Family Health. Using the existing RFTS home visitation network, Registered Nurses and Licensed Social Workers, Designated Care Coordinators (DCCs), provided services to pregnant women and infants throughout WV.

Educational tools such as videos, CO monitors, smoking cessation guides, medical models and smoking cessation incentives were available for use on home visits. Additional CO monitors and

supplies along with smoking cessation DVDs were purchased using WV Division of Tobacco Prevention grant funding in 2007. A DVD player was assigned to each DCC to use to provide more effective client education.

Data from the RFTS Project show the following quit rates among pregnant participants as follows: 2003 = 23%; 2004 = 22%; 2005 = 26%; 2006 = 27%; 2007 = 22%

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented the Smoking Cessation Program developed by Dr. Richard Windsor in January, 2002 and is ongoing. (SCRIPT)				X
2. The WV 'SCRIPT' uses the existing home visitation network and protocols in the RFTS Project.		X		
3. Information about negative effects of smoking during pregnancy is distributed to all women.			X	
4. SCRIPT provided to all willing RFTS/HAPI participants.		X		
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. All RFTS smokers/former smokers are offered CO Testing.		X		
7. State government maintains Quit Line.				X
8.				
9.				
10.				

b. Current Activities

All health care providers, especially those with direct patient contact, have a unique opportunity to help tobacco users quit. Smokers cite a doctor's advice to quit as an important motivator for attempting to stop smoking.

To assist health care providers in advising patients on the dangers of using tobacco, DTP has partnered with the Joan C. Edwards School of Medicine in Huntington, WV to offer FREE face-to-face tobacco cessation training based on the Agency for Healthcare Research and Quality (AHRQ) guidelines (www.ahrq.gov).

This training is taught by Dr. Lynne Goebel and Dr. Imran Khawaja and is available to all healthcare providers. The two hour training is conducted during evening hours and on Saturdays to allow easier access to healthcare providers. The training offers free CME and CEU credits for attendance.

c. Plan for the Coming Year

The Pregnancy Initiative strives to educate mothers, pregnant women and women who may become pregnant about the potential health consequences using tobacco inflicts on the smoker, fetus and child. Through educational materials, cessation information and media outreach, our mission is to inform women who smoke about tobacco's facts and specific dangers. The Pregnancy Initiative's ultimate goal is to encourage women to seek cessation assistance by directing them to the beneficial services of the West Virginia Quit Line.

The foundation has been laid in WV for an effective statewide initiative to reduce the number of

pregnant smokers. Although the WV RFTS SCRIPT only provides smoking cessation education to low income pregnant women and their families, this represents more than half of WV's pregnant women who are eligible for this support and public assistance.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	6	5	7	7.5
Annual Indicator	9.6	8.0	11.1	7.7	6.8
Numerator	12	10	14	9	8
Denominator	125578	125578	125578	117478	117478
Data Source					2007 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.5	6.5	6	6	6

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Statistics

a. Last Year's Accomplishments
Suicide is the third leading cause of death among United States youth between the ages of 15-24 with 4,212 reported completed suicides. Suicide is the second leading cause of death among West Virginia youth ages 15-24 with 22 reported completed suicides, 9 of which were between the ages of 15-19 in 2007. West Virginia is currently ranked 33rd nationally in suicide deaths for this age group with a rate of 9.6 per 100,000.

In March of 2006, the West Virginia Council for the Prevention of Suicide contracted with the Mental Health Association in New York City to provide statewide suicide prevention services through the National Suicide Prevention Lifeline, 1-800-273-TALK. Callers from anywhere in the State of West Virginia who calls that toll-free number are automatically routed to the Crisis Intervention Specialists at Valley HealthCare System in Morgantown, WV. Based upon the severity of the call, emergency dispatchers may be notified, callers may be referred for inpatient treatment, referred for outpatient treatment, or provided with supportive counseling over the telephone. Valley HealthCare System was chosen as the site for this service due to the

availability of trained professionals 24 hours a day seven days a week, the availability of necessary equipment, and the fact that both the Executive Director and the Suicide Prevention Coordinator of the council are both located at Valley HealthCare System

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OMCFH's Adolescent Health Initiative provides community based skill building opportunities regarding adolescent at-risk behaviors.		X		
2. The EPSDT screen contains a behavior assessment instrument used for age 10 and above.				X
3. The WV Council for the Prevention of Suicide is offering workshops across the state on how to recognize the early signs of depression.				X
4. The Council has completed a five year strategic plan for suicide prevention in WV.				X
5. The Council has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice".		X		X
6. AHI offers worshops on parent-child communication.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The West Virginia Council for the Prevention of Suicide believes education and prevention will assist our state in saving lives of our citizens. Knowing the early signs of depression and suicidal behaviors is paramount in saving someone from their first suicide attempt. The West Virginia Council for the Prevention of Suicide workshops will inform the workshop participants on how to recognize the early signs of depression and then where to go for assistance. The workshops will also explain the early signs of suicidal behaviors and again where to go for assistance. The Council also gives out crisis numbers for every county in West Virginia which has a provider that operates 24 hours, 7 days a week crisis lines.

The Council also identified the need to get legislation passed regarding training school teachers on the early signs of suicide. In November, the Council held a suicide prevention workshop specifically for police officers. The Council has worked with a group of police officers from Monongalia County to plan a Police Suicide Conference on June 16th. This is the first event of its kind to be held in West Virginia. The Council has continued to distribute poster and magnets that contain the Suicide Prevention Lifeline number across the state. In June the Council held a Suicide Prevention Conference in Charleston, WV. The conference was attended by 15 individuals, and hosted two national speakers.

OMCFH leadership participates on this Council.

c. Plan for the Coming Year

The Council Board held a board retreat and completed a strategic plan for the coming year. Some of the goals identified for the coming year were to target community awareness of suicide prevention to police officers, firemen, children, parents, and older Americans. The council is currently providing workshops on Suicide Across the Lifespan at various locations across the state. This year the Council has presented five workshops and has two more planned following our summer conference in June. Response to these workshops has been overwhelmingly

positive. The Council also has had 4 suicide assessment instruments published in the book "Innovations in Clinical Practice". The Council collaborated with Dr. William Fremouw to establish an assessment instrument for each age group, and will continue to offer trainings on the assessments in the coming year. In October the Council continued is sponsorship of the Out of Darkness Suicide Prevention Walk in Huntington, WV.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	85	98	98	98
Annual Indicator	96.5	97.3	84.9	82.9	83.3
Numerator	248	250	258	248	250
Denominator	257	257	304	299	300
Data Source					2007 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Based upon 2007 Vital Statistics - calculated only on WV residents born in state facilities

Notes - 2007
2007 Vital Statistics - calculated only on WV residents born in state facilities

a. Last Year's Accomplishments
In 2007, almost 83% of West Virginia's very low birth weight infants were delivered at tertiary care facilities. This percentage has been slowly decreasing rather than increasing for the past few years. Early recognition and transfer of high-risk mothers or sick newborns are key elements within a successful system of perinatal care. Current evidence supports the theory of maternal transport as a significant factor in the reduction of neonatal mortality rates. Each of West Virginia's three tertiary perinatal centers has 24-hour perinatal consultation "telephone hot lines", a high-risk prenatal clinic, a high-risk labor and delivery unit, a neonatal intensive care unit, and a 24-hour neonatal transport team staffed by either neonatal nurses or neonatal nurse practitioners. Both helicopters and ambulances are used and EMS arrangements are different at each of the tertiary care centers. Physicians at the tertiary care facilities reported that they were turning away both high-risk maternal transports and infant trasports, primarily due to no availability of NICU beds. Cabell Huntington Hospital reported that from January 1, 2007 through July 31, 2007, their NICU had already refused 44 neonatal transports. In addition, 41 maternal transports were refused because the NICU was full. Between October 2007 and October 2008 another of the NICUs reported turning away 31 infants due to lack of bed availability. This information was presented to the Legislative Oversight Committee on Health and Human Resources in an effort to increase attention to perinatal shortcomings in West Virginia. The State's three tertiary care facilities for neonates were at bed capacity from 2004 to 2007, with just 89 licensed beds. Recently the number of beds have been increased to a total of 118, although not all beds are

functional.

In June 2007, a nine-question, online survey was developed and sent to perinatal nurse managers at the 28 non-tertiary hospitals in West Virginia. Responses were received from 20 (71%) hospitals. Some of the findings from the transport survey included: 70% of the hospitals were not always able to get sick babies transported to NICUs, 80% of hospitals stated they were not always able to transport high-risk mothers, 62% of hospitals reported that the most common reason given for declined infant transports was lack of beds at the tertiary care center.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OMCFH advocates that all pregnant women be screened for medical risk conditions so that high risk patient care can be planned.				X
2. OMCFH fiscally supports training teams to encourage early screening and referral.				X
3. RFTS protocols support high risk patient deliveries at tertiary care.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The subcommittee on Perinatal Consultation, Transport and Outreach Education from the West Virginia Perinatal Partnership made several recommendations to increase high-risk perinatal care capacity. Among those included were: Maternal and infant transport should be available 24-hours, seven days a week for all Level I and Level II facilities in the state; West Virginia should insure that reliable, accurate, comprehensive communication systems between referring hospitals and between the transport teams and hospitals, regarding response times, capabilities and facilities be continuously up to date; West Virginia should investigate the implementation of a single call system for perinatal transport; West Virginia should investigate the possibility of making emergency maternal transport available to all community hospitals in the state; and West Virginia should establish an organized perinatal outreach education program coordinated by each of the three Level III perinatal facilities for each of their referral hospitals.

The 2009 Legislature passed a bill requiring the use of a uniform prenatal risk screening tool by all providers and for all patients. A workgroup has been re-established to fine tune an existing screening tool and to plan for implementation. This workgroup is chaired the MCH Director.

c. Plan for the Coming Year

The Perinatal Partnership and subcommittees continue to meet regularly to resolve the issues previously discussed.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	88	88	89	89	90
Annual Indicator	83.0	85.0	83.6	82.0	83.7
Numerator	17350	17700	17500	18060	18500
Denominator	20911	20834	20931	22017	22100
Data Source					2007 Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 PRAMS data

a. Last Year's Accomplishments
Eighty-two percent (82%) of West Virginia pregnant women begin prenatal care within the first trimester. A lack of access to maternity care services was identified as a major barrier for many women in rural areas of the the state. Contributing to poor access is the decline in hospital and birthing facilities. Since the 1970's, of the 64 licensed birthing facilities in the state, 33 have closed, leaving just 31 to service the state and its rural population. Of the state's 55 counties, 27 were identified as having no birthing attendants in 2006. The cost of medical liability was identified as a major barrier to the practice of attending births. Many WV physicians and CNMs are employed with facilities and organizations where medical liability cost can be covered by the state or by the Federal Tort Claims Act coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Free pregnancy testing is available at 153 sites statewide.			X	
2. Women who have a positive pregnancy test are assisted with securing health care coverage.		X		
3. Adolescents age 19 years and under are automatically eligible for OMCFH financial assistance under RFTS.		X		
4. Early prenatal care is strongly encouraged and supported				X

through all family planning efforts.				
5. The OMCFH partners with the March of Dimes to provide education targeting early prenatal care.			X	
6. The OMCFH partners with the local DHHRs to encourage referral of pregnant women who are denied Medicaid coverage for obstetrical care services.		X		
7. RFTS receives a monthly print out sent electronically from Medicaid of those women who were denied Medicaid coverage during pregnancy. RFTS notifies the person by phone and/or letter of OMCFH services available.		X		
8.				
9.				
10.				

b. Current Activities

The WV Director of Perinatal Programs and RFTS RCCs provide training and education to local DHHR office staff and other community agencies statewide on prenatal coverage supported by Title V and how to make a referral to the Project. Staff are advised to refer all women who are denied Medicaid coverage to the OMCFH for eligibility determination for maternity services coverage, which is 185%FPL. According to PRAMS survey respondents the most cited reason for not receiving prenatal care in the first trimester is due to not having insurance. Although pregnant women are usually eligible for Medicaid or the Title V maternity services benefit, time in processing applications from the time of initial contact, especially through Medicaid is a concern to some pregnant women.

c. Plan for the Coming Year

The WV OMCFH continues to support early identification of pregnant women using the state's family planning provider network. Calls from patients who wish to continue pregnancy, but need health care financing and physician care, are supported by the OMCFH toll-free line professional staff.

The WV OMCFH will continue to work collaboratively with OB providers, March of Dimes, WIC, American Lung Association, WV Perinatal Partnership, and many other groups to educate women on the health consequences of unplanned births and the importance of prenatal care.

D. State Performance Measures

State Performance Measure 1: *Decrease the percentage of high school students in grades 9-12 who are overweight or obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	12	12
Annual Indicator	13.0	14.5	14.0	14.7	14.5
Numerator	16325	18250	17600	18400	18200
Denominator	125578	125578	125578	125578	125578
Data Source					2007 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	12	11	11	10	10

Notes - 2008
based upon 2007 YRBS

Notes - 2007
2007 YRBS

Notes - 2006
Based upon 2005 YRBS

a. Last Year's Accomplishments
Data available on the problem of overweight among West Virginia youth are limited. The latest statistics are from the 2007 Youth Risk Behavior Survey. Overall, 14.7% of West Virginia high school students in grades 9 through 12 were overweight (17.6% of males and 11.7% of females). Seventeen percent (17.0%) of students were at risk of overweight, 15.0% of males and 19.0% of females. Questions on daily diets revealed that 19.8% of students ate five or more servings of fruits and vegetables each day and those who drank three or more glasses of milk were only 16.7%.

According to the National Survey on Children's Health, approximately 67,000 of 184,000 West Virginia children ages 10-17 years (36.4%) are considered overweight or obese according using BMI-for-age standards. West Virginia ranks 48th in overall prevalence, surpassed only by Mississippi, Kentucky, and the District of Columbia.

West Virginia children are more likely than their counterparts nationwide to be physically active for at least 4 days per week, but they're also more likely to spend 2 hours or more in front of a television or computer screen.

OMCFH helped fund a newsletter, completed in April 2009, called "Children with Special Health Care Needs Nutrition Newsletter to be distributed to parents/families of children with special needs. The focus was helping children lose weight. It was compiled and written by Monica Andis, MS, RD, LD through the Center for Excellence in Disabilities (CED) Program. The newsletter resulted because of requests from family members who have children with disabilities who are overweight.

More than 250 state and local policy-makers and childhood obesity prevention advocates were invited to particpate in the Robert Wood Johnson Foundation's Leadership for Healthy Communities' childhood obesity prevention policy summit that was held May 7-8, 2009 in the nation's capital. In 2003, the WV Medical Foundation received a grant from the Claude Worthington Benedum Foundation to convene a statewide coalition (now named the Partnership for a Healthy WV) comprised of business, education, healthcare, non-rofit and government organizations to develop a collaborative effort to address the problem of obesity in the state. The group provided policy recommendations to Governor Joe Manchin that were incorporated into the WV Healthy Lifestyle Act of 2005. This legislation established an Office of Healthy Lifestyles and a 13 member Coalition chaired by First Lady Gayle Manchin.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. National companies have agreed to remove harmful soft drinks from school machines				X
2. The DHHR Office of Healthy Lifestyles promotes physical activity				X
3. Recent legislation mandates three 30 minute physical activity				X

periods during each week of the school year				
4. The West Virginia Department of Education is promoting healthy lifestyles				X
5. Cardiac Project provides free school-based BMI, BP, etc. for elementary and middle school students		X		
6. The Kids First Screening Initiative and EPSDT assessments capture BMI.				X
7.				
8.				
9.				
10.				

b. Current Activities

The WV Bureau for Public Health has partnered with the WV Department of Education's Office of Healthy Schools to address the WV Healthy People 2010 Objectives. Collaborative projects have included collecting data to establish baselines, completing inventories, developing Walk to School initiatives, and training principals.

Coronary Artery Risk Detection in Appalachian Communities (CARDIAC) is facilitated by West Virginia University. This Project is a partnership between local schools and the Rural Health Education Partnership primary care centers. Fifth-grade students are screened for cholesterol, hypertension, and obesity. Over the ten years of the Project, more than 60,000 children have received BMI measurement, testing for cholesteral, etc. Comprehensive chronic disease risk factor assessment is unique to WV's children and is useful in predicting consequences of weight status.

Healthy Hearts is a web-based instructional module for children on cardiovascular health. This is one of the first instructional (e-learning) modules that uses the Internet to teach youngsters about the risk factors associated with cardiovascular disease (cholesterol, poor nutrition, physical inactivity, and tobacco use). This project was piloted in approximately 20 fifth-grade classrooms and will allow student knowledge, attitudes, and behaviors related to nutrition, physical activity, and tobacco to be studied.

c. Plan for the Coming Year

The West Virginia OMCFH indirectly supports early identification of weight problems through the HealthCheck Program, the state's EPSDT Program. Through its protocols, medical practitioners conducting well-child examinations are instructed to measure children for height and weight, to document that information and to discuss topics of proper weight and nutrition with parents.

To this end, West Virginia plans to continue to try everything from dance-related video games in schools to increasing the amount of time spent in physical education classes, all aimed at combating a problem that costs state health plans more than $200 million annually.

Medicaid Managed Care organizations are offering counseling for high risk populations for weight control and healthy eating habits.

Camp NEW YOU, offered by the WVU School of Medicine and the School of Physical Education provides opportunities for youth and their parents to practice lifestyle changes that enable them to achieve and maintain a healthy body weight. This residential camp is available on the college

campus and targeted to 11-14 year olds.

State Performance Measure 2: *Decrease the percentage of high school students who smoke cigarettes daily.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			19	18.5	18
Annual Indicator	21.5	19.3	19.0	19.5	19.4
Numerator	26999	24236	23800	24500	24300
Denominator	125578	125578	125578	125578	125578
Data Source					2007 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17.5	17	16.5	16	16

Notes - 2008
Based upon 2007 YRBS

Notes - 2007
2007 YRBS

Notes - 2006
Based upon 2005 YRBS

a. Last Year's Accomplishments
The 2007 YRBS shows that the percentage of students who ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days has increased slightly to 19.5%, however the 2007 YRBS also shows that smoking within the last 30 days has decreased from 38.5% in 2000 to 28.8% in 2007. The percentage who reported they have never smoked cigarettes rose from 25.7% to 38.9% from 2000 to 2007.

RAZE, the statewide teen-led, teen-implemented anti-tobacco movement, is coordinated by the Youth Empowerment Team (YET). YET members include representives of the Division of Tobacco Prevention, the West Virginia Department of Education's Office of Student Services and Health Promotion, the American Lung Association of West Virginia and the West Virginia Youth Tobacco Prevention Campaign. The goal of Raze is to create a statewide youth anti-tobacco movement that initiates concern and activism, with peer-to-peer influence ultimately reducing tobacco use among teens. Their vision statement is: We are Raze: West Virginia teens, tearing down the lies of Big Tobacco and fighting them with all we've got: our passion, our power and our minds. Join up, if you think you can handle it.

Raze Crews, groups of teens making a difference, are in over 140 schools and communities in West Virginia.

TAC (Teen Advisory Council) members get a chance to be in charge of a number of important duties for Raze. TAC members meet once a month either in person or by conference call. TAC plans, organizes and implements a number of various trainings and commotions. They also provide feedback on Raze issues such as ads, gear, etc.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR and Department of Education have strong anti-tobacco programs which include a brand and promotional campaign designed in advice from youth in this age group.			X	
2. The Adolescent Health Initiative warns of the dangers of tobacco use.		X		
3. Raze is West Virginia's teen led anti-tobacco movement.			X	
4. Smoking bans in government buildings and state vehicles.				X
5. As of January 2009, all 55 counties have clean indoor air regulations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Initiative (AHI) and the Abstinence Education Project (AEP) educate youth about the consequences of tobacco use and encourage responsible behavior. Both programs partner with RAZE and other prevention programs to facilitate community-based activities and events promoting awareness.

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals: (1) Prevent the initiation of tobacco products among young people; (2) Eliminate exposure to secondhand smoke; (3) Promote quitting among adults and young people; (4) Eliminate tobacco-related disparities among different population groups.

c. Plan for the Coming Year

West Virginia's Youth Tobacco Prevention Program's goal is to prevent WV's youth from using tobacco products, even trying them, and to assist the youth who are using tobacco products in reducing the amount they use or quitting. The Youth Program works closely with the WV Department of Education (WVDE) on tobacco related issues including policy and enforcement. The Regional Tobacco Prevention Specialist (RTPS) Network is facilitated and managed through the Office of Healthy Schools, WVDE and the Division of Tobacco Prevention, WVDHHR. The Youth Program also collaborates with the American Lung Association of WV (ALA) to address the community needs of the state and provide facilitation for both schools and communities. The WVDE and the ALA work with the Youth Program and The Arnold Agency to support Raze. Raze is West Virginia's teen led anti-tobacco movement. For more information go the Raze website at www.razewv.com

State Performance Measure 3: *Decrease the percentage of pregnant women who smoke.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			24	23	22
Annual Indicator	27.0	32.0	29.0	30.0	27.1

Numerator	5650	6670	6070	6595	6000
Denominator	20911	20834	20931	22017	22100
Data Source					2006 PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21	20	20	20	20

Notes - 2008
based upon 2007 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2007
2007 PRAMS data - mom smoked last 3 months of pregnancy

Notes - 2006
2006 PRAMS data

a. Last Year's Accomplishments
The purpose of the tobacco free pregnancy initiative through the Division of Tobacco Prevention(DTP) within the Bureau for Public Health is to educate women of child-bearing age as well as those who are pregnant on the dangers of using tobacco ald also, to educate every healthcare provider on the urgent need for face-to-face tobacco cessation counseling.

The Tobacco Cessation Program is funding several projects: The Tobacco Free for Baby and Me Program administered by CAMC-Women's and Children's Hospital is now in its second year of providing tobacco cessation counseling through its high-risk OB clinic; The DHHR Office of Maternal Child and Family Health offers tobacco counseling during in-home visits through the Right from the Start network; The Day One Project offered by the WV Hospital Association is providing education on the dangers of second-hand smoke to new mothers and their families after the child is born and; The Women, Infants and Children (WIC) Office of Nutrition Services is partnering with DTP to distribute educational materials to those women who receive services through the 55 clinics throughout WV.

Smoking during pregnancy can cause stillbirth, low birthweight, Sudden Infant Death Syndrome (SIDS), and other serious pregnancy complications and this is referenced on public informing materials.

The WV Tobacco Quitline, administered by beBetter Networks, Inc., was first launched as the YNOTQUIT Program on July 1, 2000, as a service for WV Medicaid recipients and members of the WV Public Employees Insurance Agency. In March 2002, the Program received sponsorship by the WV Bureau for Public Health and was available to all 1.8 million WV citizens. Over the course of seven years of operations, the WV Tobacco Quitline has received over 243,000 calls and enrolled more than 50,650 individuals.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implemented the Smoking Cessation Program (SCRIPT) developed by Dr. Richard Windsor in January 2002 and is ongoing.				X
2. The WV SCRIPT uses the existing home visitation network and protocols in the RFTS Project.		X		
3. All pregnant RFTS smokers/former smokers are offered CO		X		

Testing and Smoking Cessation.				
4. SCRIPT mandated to be offered to all RFTS/HAPI participants.				X
5. Information collected in OMCFH Research Division's Tobacco Screening databases.				X
6. The effects of smoking during pregnancy are distributed universally.			X	
7. State government maintains Quit Line.				X
8.				
9.				
10.				

b. Current Activities
All health care providers, especially those with direct patient contact, have a unique opportunity to help tobacco users quit. Smokers cite a doctor's advice to quit as an important motivator for attempting to stop smoking.

To assist health care providers in advising patients on the dangers of using tobacco, DTP has partnered with the Joan C. Edwards School of Medicine in Huntington, WV to offer FREE face-to-face tobacco cessation training based on the Agency for Healthcare Research and Quality (AHRQ) guidelines (www.ahrq.gov).

This training is taught by Dr. Lynne Goebel and Dr. Imran Khawaja and is available to all healthcare providers. The two hour training is conducted during evening hours and on Saturdays to allow easier access to healthcare providers. The training offers free CME and CEU credits for attendance.

The OMCFH SIDS Project is sending postcard reminders to all parents of newborns on the dangers of smoking around their new infant, sleeping with their infant, using softbedding, as well as, to put their infant to sleep on its back.

c. Plan for the Coming Year
The Pregnancy Initiative strives to educate mothers, pregnant women and women who may become pregnant about the potential health consequences using tobacco inflicts on the smoker, fetus and child. Through educational materials, cessation information and media outreach, our mission is to inform women who smoke about tobacco's facts and specific dangers. The Pregnancy Initiative's ultimate goal is to encourage women to seek cessation assistance by directing them to the beneficial services of the West Virginia Quit Line.

RFTS care coordinators wil be offered additional training on motivation interviewing.

State Performance Measure 4: *Increase the percentage of women who breastfeed their infants for at least six (6) weeks after birth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			37	38	57
Annual Indicator	30.0	22.0	56.0	32.5	33.9
Numerator	6270	4580	11730	7150	7500
Denominator	20911	20834	20931	22017	22100

Data Source					2007 PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	55	55	55	55

Notes - 2008
based upon 2007 PRAMS data - mom breastfeeding at 8 weeks

Notes - 2007
2007 PRAMS data - mom breastfeeding at 8 weeks

Notes - 2006
2006 PRAMS data - women who initiated and breastfed for any amount of time

a. Last Year's Accomplishments
While the latest data on breastfeeding indicates that a low percentage of women choose to breastfeed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal, Child and Family Health (OMCFH). All pregnant women participating in the Right From The Start Project (RFTS) receive information about the benefits of breastfeeding their infants. RFTS Project DCCs provide comprehensive in-home breastfeeding education and support to prenatal participants through sixty days post partum and to breastfeeding mothers of eligible infants until their infant reaches age one year.

The RFTS Project encourages collaboration with local WIC offices statewide to ensure that participants continue to receive breastfeeding education and support after case closure. After learning of ineffective community collaboration between RFTS and West Virginia WIC providers, the Director of Perinatal Programs voiced concerns regarding this matter to the Director of the Office of Nutrition Services. RFTS DCCs report that collaborative efforts have improved. This improvement provided RFTS participants with better continuity of care and resulted in an increase in the number of pregnant women referred to RFTS for care coordination. This in turn provided an opportunity for more breastfeeding education and support and is evidenced by the steady increase in breastfeeding rates of RFTS Project participants reported above.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase WIC resources money and personnel dedicated to breastfeeding.				X
2. WIC goals include providing additional funds to local agencies that will allow breastfeeding peer counselors to visit local hospitals and physicians practices in order to keep mothers breastfeeding longer.				X
3. Increase attention by multiple service agencies serving pregnant women including physicians, RFTS, etc. need to encourage and offer breastfeeding support.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WIC and RFTS Project participants are encouraged to breastfeed and educated on health and socioeconomic benefits to mother and infant. Some long-term benefits discussed regarding breastfeeding are reduced childhood obesity, reduced risk of some chronic diseases, decreased risk of allergies, improved neurological development, higher IQs, better eyesight, increased jaw strength and straighter teeth as a direct result of suckling at the breast.

Women are educated about the health benefits for themselves including reduction of postpartum blood loss, increased postpartum weight loss with no return of weight once weaning occurs, possible delay of fertility, less need for insulin in diabetic mothers, psychological benefits, enhanced mother/infant bonding, reduced risk of breast, ovarian and endometrial cancers, reduced risk of osteoporosis and bone fracture.

c. Plan for the Coming Year
The RFTS Project will continue to provide educational materials on breastfeeding such as videos, pamphlets, and literature for DCCs to use during home visits. RFTS DCCs promote breastfeeding with each prenatal participant and provide support and referrals as needed. RFTS will continue to train DCCs on the benefits of breastfeeding and how to encourage participants to try breastfeeding as their first choice for infant feeding.

Women can be encouraged to breastfeed longer into the postpartum period by being educated to seek assistance from local support groups, other mothers who have successfully breastfed and from their local WIC lactation consultants.

The Director of Perinatal Programs and the RFTS RCCs will continue collaborative efforts with staff of the WV Office of Nutrition Services to ensure that local WIC offices refer clients to the RFTS Project and work effectively with DCCs.

State Performance Measure 5: *Decrease the percentage of high school students who drink alcohol and drive.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			10	10	9.5
Annual Indicator	12.0	10.6	10.4	10.0	9.8
Numerator	15069	13300	13000	12500	12300
Denominator	125578	125578	125578	125578	125578
Data Source					2007 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9	8.5	8	8	8

Notes - 2008
Based upon 2007 YRBS

Notes - 2007
2007 YRBS

Notes - 2006
Based on 2005 YRBS

a. Last Year's Accomplishments
The West Virginia Abstinence Education Project (AEP), in partnership with the COFY Coalition developed Drug-Free All-Stars, a basketball team comprised of community prevention partners, law enforcement and local business leaders in Wyoming, Mercer and McDowell Counties. The team plays students and teachers at local schools while promoting healthy lifestyle choices.

The Director for the Adolescent Health Initiative partnered with the Kanawha County Communities That Care partnership and the Kanawha County Sheriff's office to obtain $19,850 grant to combat underage drinking. The funds were used to pay for "alcohol sting" activities such as DUI checkpoints, sending kids into stores to try to buy alcohol, shoulder tap activities, and utilizing undercover police officers to pose as employees in businesses that sell alcohol.

The Region VII AHI Coordinator conducted six workshops on alcohol prevention at Doddridge County High School Teen Issues Day.

The AEP, in partnership with other prevention programs and community leaders, sponsored Drug Free Alternative Day in McDowell County. Parents and youth received prevention information on alcohol, tobacco and other drugs.

The AEP sponsored Dr. Mike, a character education speaker for school students in Taylor and Marion Counties. Students were encouraged to make positive choices including abstinence from sex, alcohol, tobacco and other drugs.

The AEP sponsored an alcohol-free "After Prom Party" in Ritchie County, WV.

House Bill 4023, Satisfactory Progress in School to keep Driver License, adds additional criteria of "attendance" and "satisfactory progress" for persons under the age of 18 to the reasons for triggering either the school notice to DMV to suspend, or the refusal of the school to issue the document required to obtain a driver's license.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Students Against Destructive Decisions (SADD) works with communities to establish local chapters.		X		
2. Adolescent Health Initiative promotes healthy decision making.			X	
3. State alcohol distribution policy protects youth.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Adolescent Health Initiative (AHI) and the West Virginia Abstinence Education Project (AEP) partner with SPF-SIG implementation grant recipients across the state to develop substance abuse prevention plans for nineteen of West Virginia's fifty-five counties.

The AHI and AEP Coordinators participate in substance abuse coalitions across the state including, but not limited to, Upshur, Doddridge, Monongalia, Lewis, Brooke, Hancock, Ohio,

Marshall, Greenbrier, Fayette and Summers Counties. These coalitions are comprised of school counselors, law enforcement, school-based health professionals, mental health professionals, parents, youth and other community and business partnerships.

The AEP disseminates information at high school proms across West Virginia educating students about the dangers of sexual activity, alcohol and drug use.

West Virginia implemented the graduated driver licensing program. Under the new system, teen drivers are eligible for an instruction permit (Level 1) at age 15, an intermediate license (Level 2) at age 16, and a full license (Level 3) at age 17.

c. Plan for the Coming Year
In FY 2006 there were 299 sobriety checkpoints and 243 DUI arrests. Saturation and directed patrols resulted in 39,356 driver contacts with 1,079 persons arrested for DUI offenses. In FY 2007 there were 350 sobriety checkpoints and 168 DUI arrests. Saturation and directed patrols resulted in 51,880 driver contacts and 1,353 DUI arrests. In FY 2008, there were 471 sobriety checkpoints with 204 DUI arrests. Saturation and directed patrols yielded 52,441 driver contacts and 1,602 DUI arrests. Significant progress has been achieved in this area. Funding is in place to continue this effort through 2009.

State Performance Measure 6: *Decrease the number of high school students who never or rarely wear a seatbelt when riding in a car driven by someone else.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			15	14.5	14
Annual Indicator	15.2	15.2	15.0	16.6	16.4
Numerator	19087	19087	18800	20800	20600
Denominator	125578	125578	125578	125578	125578
Data Source					2007 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13.5	13	12.5	12	12

Notes - 2008
Based upon 2007 YRBS

Notes - 2007
2007 YRBS

Notes - 2006
Based on 2005 YRBS

a. Last Year's Accomplishments
The Governor's Highway Safety Program (GHSP) became eligible for NHTSA Section 406 Funding in the amount of $5 Million in 2008 because they met the funding criterion for a seatbelt usage rate of 85 percent or greater in 2006 and 2007.

Activities targeted at this age group include statewide compliance checks twice yearly: one during prom season and the second during the national DUI mobilization. The Governor's Highway Safety Program, West Virginia State Police, the Alcohol, Beverage, Control Agency(ABCA), and local law enforcement agencies in Cabell and Monongalia Counties are working on a program, which ABCA calls Dream Savers. This is a maximum enforcement effort in these counties, where

our two major universities are located, to prevent underage access to alcohol, and requires the cooperative efforts of all participating agencies. The Governor's Highway Safety Program and ABCA are working with every college in the state to address underage drinking on and around each college campus. The colleges have recently formed a state organization to help implement its programs.

The Governor's Highway Safety Program sponsors Students Against Drunk Driving (SADD) Programs throughout the state. WV SADD operating out of the city of Huntington program, maintains the WV Student Leadership Council (SLC). WV SADD has had four students selected for the National SADD SLC and has received national recognition for producing student leaders. (four students on the National SADD SLC from a state the size of WV is unprecedented)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WV Department of Transportation promotes seat belt use.				X
2. WV Department of Public Safety sponsors the "Click It or Ticket" campaign and has put an emphasis on enforcement of seat belt usage laws.				X
3. WV state law requires seat belt use.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The West Virginia Highway Safety Office has some interesting programs, one of which is called Battle of the Belts. High Schools agree to participate. A baseline survey is done on seatbelt use as kids pull into the parking lot in the morning for school. Schools are given 30 days to improve the use percentage by any means they think will work. The survey is repeated 30 days later. The most improved schools receive cash prizes. The Project varies by region throughout the State.

On May 17, 2009, Law enforcement officials were out in full-force to ensure motorists and their passengers were buckled up as part of the Click-It-or-Ticket, an annual national campaign designed to increase the percentage of safety belt usage. According to Police Sgt. Paul Blume, coordinator of the Southern Regional Highway Safety Program, the campaign, since 2000, has helped West Virginia climb from 49 percent to right at 90 percent.

c. Plan for the Coming Year

In June of 2007 a scientific seatbelt survey was conducted in West Virginia. The results of this study revealed that 89.6% of front seat occupants were wearing their seatbelt. This is a 40.1% increase since FY 2000. We are striving for a 92% usage by FY 2010.

Effective July 10, 2009, young drivers in West Virginia who choose not to enroll in driver education will be required to drive for 50, rather than 30, supervised hours in the learner's phase. Provisional license holders will be prohibited from driving from 10 pm to 5 am instead of the previous 11 pm to 5 am. Additionally, the passenger restriction will strengthen from no more than

three passengers to no passengers for the first six months and not more than one passenger for the second six months.

State Performance Measure 7: *Increase the percentage of the state's children <18 who are government sponsored beneficiaries who have at least one primary care visit in a 12-month period.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			90	90	90
Annual Indicator	87.8	88.2	88.7	89.6	81.4
Numerator	199564	200354	232500	233427	158651
Denominator	227222	227222	262222	260614	194998
Data Source					CMS-416 Fiscal Year 2008 Annual Report
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	92	92	93	93

Notes - 2008
CMS-416 Fiscal Year 2008 Annual Report

a. Last Year's Accomplishments
West Virginia is ahead of most other states when it comes to getting children access to health care, according to a recent study. A report released by The Commonwealth Fund ranks West Virginia in the top quartile overall. The Mountain State also has the highest ranking in providing specialty care to children. West Virginia provides public health insurance for many of its children partly through agencies like Medicaid and the State Children's Health Insurance Program.

Of the children enrolled in WVCHIP for Fiscal Year 2008, 100% of the children ages less than or equal to 15 months had a well child visit with a physician. Of the children ages 0 through 6 years of age 94.53% enrolled in WVCHIP had a well child check-up. Nearly eighty-three percent (82.85%) of children enrolled in WVCHIP ages 12 to 19 years had a well visit with a physician.

For FY 2008, of the 13,829 children less than one year old eligible for Medicaid, 13,431 (97.12%) received at least one initial or periodic screen. The participation rate for children ages 1-2 was 60.7%, ages 3-5 was 43.2%, ages 6-9 was 24.42%, ages 10-14 was 23.88%, ages 15-18 was 17.44% and for ages 19-20 it was 4.93%. Overall participation rate was 28.85%.

EPSDT/HealthCheck utilization remains at 50%. EPSDT Family Outreach Workers, located in nine regions of the State, inform parents and care-takers of Medicaid eligible children not enrolled in Medicaid Managed Care about EPSDT services locating a medical home and encourage them to use the EPSDT services for preventive health. A Program Specialist employed by OMCFH is assigned to each region and provides orientation of new EPSDT providers, technical assistance, orientation of new staff members, an Annual Review of all EPSDT program requirements, and a minimum of two site visits each fiscal year for all existing EPSDT providers.

The OMCFH HealthCheck staff only does outreach for EPSDT members not assigned to an HMO. Forty-four counties are covered 100% by HMOs and another 7 counties are covered by one HMO and PAAS. HealthCheck only serves the fee for service clients, PAAS clients, SSI

clients, and foster children. PAAS, is a state managed patient enrollment per member/per month to a physician as an HMO-like option.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote routine health care utilization via Healthy Schools			X	
2. Promote the Governor's Kid First Initiative to screen kindergarten kids using HealthCheck protocols			X	X
3. 100% of children in program receive notification about needed screens		X		
4. Participate in development of public informing materials				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WVCHIP continues to partner with several State agencies and community health programs as a way to refocus WVCHIP's outreach efforts as a leader in health prevention and promoting a healthy lifestyle. Collaborations are important to allow multiple agencies and entities inside and outside state government to integrate efforts related to a statewide mission for the health of West Virginia's children. WVCHIP has embarked on several health intervention and prevention initiatives that have involved the Infant, Child, and Adolescent Division within OMCFH as well as other Offices within the Bureau for Public Health.

Currently, WVCHIP is focusing on educating families on the importance of well-child visits, immunizations, reducing unnecessary emergency room visits, child development and asthma and diabetes case-management.

Several groups and coalitions have asked Medicaid to revise its newly redesigned Medicaid plan. They contend that the redesign will not get the intended results.

The Kids First Screening Initiative was launched last year with the support of WV Govenor, Joe Manchin. Kids First's Healthcheck is a comprehensive screening that includes hearing, speech, language, and growth and development. Beginning the school year 2008-09, all children enrolling in kindergarten received this exam.

c. Plan for the Coming Year

The EPSDT Program will continue to be operated by the OMCFH through a contractual arrangement with the Bureau of Medical Services and renegotiated every year. EPSDT has contracted with the Health Maintenance Organizations (HMO) to provide outreach services for their child beneficiaries to encourage their participation in EPSDT. EPSDT providers plan to continue offering EPSDT services in the School Based Health Centers as a way to be more accessible for those children who may not otherwise receive services due to restricted access.

EPSDT has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides orientation for HMO providers serving Medicaid enrolled children. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community often lacks capacity in some areas of the state.

The health care reform bill is the expansion of the Children's Health Insurance Program to include families with incomes up to 300% FPL. Over the next few years an additional 4,000 plus West Virginia children will receive health insurance through this expansion. The CHIP expansion is projected to achieve a 97% rate of children who have health insurance.

WVCHIP will continue partnerships with several State agencies and community health programs and focus on healthy lifestyles and prevention efforts.

The West Virginia Small Business Plan will continue to allow small businesses access to the buying power of the Public Employees Insurance Agency (PEIA). Through a private-public partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies that choose to offer the plan, the West Virginia Small Business Plan allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly. PEIA is the largest self-insured plan in the state, providing insurance to public employees in state agencies, state universities, and colleges, as well as county boards of education. The Small Business Plan has similar goals to group purchasing arrangements because it builds on the buying power of a large group.

State Performance Measure 8: *Increase the percentage of high school students who participate in physical activity for at least 20 minutes a day, 3 days a week.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			68	69	50
Annual Indicator	66.3	63.7	65.0	42.8	43.0
Numerator	83258	79993	81600	53700	54000
Denominator	125578	125578	125578	125578	125578
Data Source					2007 YRBS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	55	55	60	60

Notes - 2008
Based upon 2007 YRBS - question is actually stated as percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

Notes - 2007
2007 YRBS - question is actually stated as percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

Notes - 2006
Based on 2005 YRBS

a. Last Year's Accomplishments
According to the 2007 National Survey of Children's Health, Indicator 1.5: "During the past week, on how many days did [child name] exercise, play a sport, or participate in physical activity for at least 20 minutes that made [him/her] sweat and breathe hard?" reports that 10.0% of WV children age 12-17 exercised/did physical activity 0 days in the past week, 28.4% exercised/did physical activity for 1-3 days in the past week, 35.4% exercised/did physical activity 4-6 days in the past week, and 26.3% exercised/did physical activity everyday in the past week.

NSCH numbers differ so greatly from the 2007 YRBS because the YRBS question is actually

stated as percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past seven days.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WV DHHR Office of Healthy Lifestyles promotes physical activity				X
2. Recent legislation requires three periods of physical activity each week (30 minutes in length) during the school year for grade school				X
3. Recent legislation requires one semester each year for middle school				X
4. Recent legislation requires one class of physical education during high school				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Physical education can be a vehicle through which high school students transition from adolescence to adulthood. High school physical education programs should focus on fitness, offer diverse movement patterns, development of motor skills and emphasize lifetime activities. Students need to be exposed to a wide variety of activities, both competitive and noncompetitive that bring them enjoyment and challenge, thus enabling them to maintain an active lifestyle for a lifetime. The West Virginia Standards for 21st Century Learning include the following components: 21st Century Content Standards and Objectives and 21st Century Learning Skills and
Technology Tools. All West Virginia teachers are responsible for classroom instruction that integrates learning skills, technology and objectives.

Note: In accordance with W. Va. Code SS1827a, the FITNESSGRAM(r) shall be administered to all students.

An attachment is included in this section.

c. Plan for the Coming Year

The WV Board of Education believes that county boards of education can make a positive impact on promoting healthy lifestyles among students and staff through the development and implementation of proactive local wellness policies. In addition, the Board believes all schools should provide a consistent environment that is conducive to healthful eating behaviors and regular physical activity. The WVBE set forth expectations and encouraged county boards to prepare, adopt and implement a comprehensive nutrition and physical activity plan that included specific standards.

E. Health Status Indicators

Introduction

Improvement in the health of West Virginia's perinatal population is a result of a carefully crafted, highly-interdependent partnership. Tertiary care centers, primary care centers, local health departments, private practitioners and community agencies have worked with the Office of Maternal, Child and Family Health (OMCFH) for nearly 30 years to improve the health and well-being of the State's people. In conjunction with its medical advisory boards, OMCFH has designed a system that offers early and accessible health care to low income, medically indigent and underinsured women and children. A successful system requires adequately trained professionals to provide complete reproductive health services that include family planning, preconceptual counseling, prenatal care, delivery, newborn care, and care for the woman in the postpartum period.

OMCFH has a commitment of ensuring healthy births, reducing the incidence of low birth weight, and improving the health status of West Virginia's children. OMCFH also recognizes the importance of maximizing scarce fiscal resources and the benefit of collaborative efforts in the development of programs that support shared goals. West Virginia's efforts to improve the health status of pregnant women and children have been successful over time as evidenced by broadened medical coverage, streamlined medical eligibility processes, shared government funding, targeted outreach, risk reduction education, and development of comprehensive programs.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.3	9.5	9.7	9.5	9.0
Numerator	1950	1984	2020	2102	2000
Denominator	20911	20834	20931	22017	22100
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Based upon 2007 Vital Statistics

Notes - 2007

2007 Vital Statistics

Notes - 2006

2006 Vital Stats

Narrative:

/2010/ West Virginia has struggled with the incidence of low birth weight infants. Birth weight is the single most important predictor of survival. Low birth weight is defined as a weight of less than 2,500 grams at birth and may result from preterm birth (before 37 weeks) or poor fetal growth for a given duration of pregnancy (intrauterine growth retardation) or both. Risk factors for preterm birth and low birth weight include: previous preterm and/or low birth weight birth, multiple births, smoking, unplanned pregnancy,

infections, poor nutrition, lack of access to adequate and early prenatal care, harmful substance abuse, and domestic violence.

The RFTS Project provides in-home care coordination to Medicaid-eligible and high risk population of pregnant women and infants. In 2008, data show the average birth weight for an infant born to Project participants was 6.95 pounds.

The high incidence of low birth weight is concentrated in a small number of counties. Activities to address this include RFTS follow-up to discuss nutrition during pregnancy, enrollment in WIC, and education on the importance of adequate and early prenatal care and smoking cessation.

There was a total of 2,094 low birthweight babies (those weighing less than 2,500 grams or 51/2 pounds) born to West Virginia residents in 2007, 9.5% of all births. Of the 2,094 low birthweight infants, 1,413 or 67.5% were preterm babies born before 37 weeks of gestation. (Of all 2007 resident births with a known gestational age, 12.5% were preterm babies.) Of the births with known birthweight, 9.3% of babies born to white mothers and 14.9% of babies born to black mothers were low birthweight. Nationally, 8.3% of all infants weighed less than 2,500 grams at birth in 2006; 7.3% of white infants and 14.0% of black infants were of low birthweight. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.5	7.4	9.1	7.8	7.7
Numerator	1572	1537	1912	1725	1700
Denominator	20911	20834	20931	22017	22100
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Statistics

Narrative:
/2010/ While it is desired for all newborns to be born at a healthy weight, some factors are hard to influence. In regard to too little and too soon newborns, it is our intent to use maternal risk screening as a means of assuring predicted high birth babies are birthed at hospitals appropriate to meet need. Prevention efforts have been repeatedly discussed throughout this application. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.5	1.6	1.5	1.6	1.5
Numerator	322	339	304	359	325
Denominator	20911	20834	20931	22017	22100
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Stats

Narrative:
/2010/ The percent of live births weighing less than 1,500 grams varies from 1.5 to 1.6. In 2007, 359 infants were born weighing less than 359 grams. Of those infants, 355 or 98.9% were born before 37 weeks gestation. Of the infants weighing less than 1,500 gms, 332 (92.4%) were white, 25 (7%) were black and 2 (.6%) were of another race. Of the 359 infants weighing less than 1,500 grams 71 or 19.7% died before one year of age.

Over one-fourth (26.8%) of the 22,017 births in 2007 were to mothers who smoked during their pregnancies, while 0.3% of births were to women who used alcohol. National figures from 2005 show that 10.7% of women giving birth reported smoking during pregnancy; 0.8% used alcohol in 2004 (the latest data available). Among the state mothers who reported smoking during pregnancy, 14.2% of the babies born were low birthweight, compared with 7.8% among non-smoking mothers. Over one-third (35.6%) of 2007 state births were delivered by Cesarean section, compared with a 2006 national rate of 31.1%. One or more complications of labor and/or delivery were reported for 31.6% of deliveries in the state in 2007. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.1	1.2	1.1	1.2	1.1
Numerator	240	245	239	255	250

Denominator	20911	20834	20931	22017	22100
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Statistics

Narrative:
/2010/ The percent of WV live singleton births weighing less than 1,500 grams fluctuates between 1.1% and 1.2%. HB 2837, the Uniform Maternal Screening Act, passed during the 2009 WV Legislative session establishes an advisory council within the WV DHHR, Office of Maternal, Child and Family Health to assist in developing a uniform maternal risk screening tool. Once developed, all health care providers offering maternity services will be required to utilize the tool in their examinations of any pregnant woman, maintain confidentiality and notify the woman of any high-risk condition which they identify along with any necessary referral. In 2008, providers submitted 4,898 referrals to the Right From The Start Program for pregnant women who were eligible to receive targeted case management services. The eligible population is all Medicaid-eligible pregnant women and their infants. This was aprroximately 48% of the Medicaid-eligible population in WV.

A uniform approach will simplify the process, standardize procedures and identify pregnancies that need more in-depth care and monitoring. Additionally, a uniform application will provide measurable data regarding at-risk and high-risk pregnancies. This will allow public health officials to analyze conditions that are most frequently observed and to develop methodology to address concerns. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	10.9	7.0	8.2	9.5	8.8
Numerator	36	23	27	30	28
Denominator	329137	329137	329137	316809	316809
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Statistics

Narrative:
/2010/ Injury has been called the neglected disease of modern society. Among persons aged 1-34 years, unintentional injuries are the leading cause of death in the United States. In WV, unintentional injuries were the leading cause of death for ages one through 44 years. Motor vehicle accident fatalities remained the single leading cause of death for young adults aged 15 through 24, accounting for 34.7% of all deaths for this age group in 2006. West Virginia's 2007 motor vehicle fatalities included six children under five years of age, same as 2006. Accidental poisoning accounted for over one-fourth (25.6%) of all deaths in the age group of 25-34. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.3	3.6	4.6	5.4	4.7
Numerator	14	12	15	17	15
Denominator	329137	329137	329137	316809	316809
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Statistics

Narrative:
/2010/ Traffic fatalities in West Virginia have dropped from 431 deaths in 2007 to 378 in 2008, based on data collected by highway officials. The police department states they have significantly stepped up efforts to crack down on aggressive and drunken driving in the past few years. The police department credits most of its success to high visibility enforcement and their media messages. They noted the flurry of seatbelt and anti-drunken driving commercials that air throughout the day. The Click It or Ticket campaign has been especially effective relying heavily on targeted advertising aimed at getting teens and

young adults to use their seat belts. Law enforcement efforts to deter drunken drivers also play a significant factor. West Virginia holds more sobriety checkpoints per capita than any other state.

In 2007, of the 76 young persons ages 0-21 killed in crashes, 41 did not use any occupant protection and 10 were unknown. Only 25 were using any type of protection such as a lap and shoulder belt, child safety seat, motorcycle helmet, etc. In 2008, of the 59 young persons ages 0-21 killed in crashes, 25 did not use any occupant protection and 7 were unknown. Twenty-seven persons were using some type of occupant protection. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	37.4	37.0	39.9	36.1	34.8
Numerator	92	91	98	83	80
Denominator	245687	245687	245687	229772	229772
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Based upon 2007 Vital Statistics

Notes - 2007
2007 Vital Statistics

Notes - 2006
2006 Vital Stats

Narrative:
/2010/ Motor vehicle accidents are the leading cause of death for West Virginia children ages 15 through 24. Of the 260 adolescents who died in 2006 in this age group, 98 (37.7%) were due to motor vehicle accidents. In 2007 of the 238 adolescents who died in this age group, 83 or 34.9% were due to motor vehicle accidents. In 2004, West Virginia implemented one of the most visible Click It or Ticket enforcement and media efforts ever conducted in the State. Approximately 9,500 safety belt and 455 child safety seat citations were written during the two-week period. In addition, West Virginia police made 910 DUI, 1,099 felony, and 776 drug arrest, and issued 17,927 speeding and reckless driving tickets.

In 2000, West Virginia had the lowest seat belt usage rate in the country at 49%. The rate went to 52% in November 2001. As a direct result of the Click It or Ticket Program, with the assistance of our law enforcement partners, and a large paid media effort, West Virginia's seat belt usage rate soared to an all time high of 72% in June 2002. In June of 2003, after another sucessful year of the Click It or Ticket campaign, the usage rate jumped to 74%. In June of 2004, the seat belt usage rose another two percentage points to 76% and in June 2005, a scientific seat belt survey was conducted in West Virginia and the results were 85% were wearing their seat belt. The percentage of seat belt useage rose to 88.5% in 2006 and to 89.5% in 2007.

The West Virginia Highway Safety Office has some interesting programs, one of which is called Battle of the Belts. High Schools agree to participate. A baseline survey is done on seatbelt use as kids pull into the parking lot in the morning for school. Schools are given 30 days to improve the use percentage by any means they think will work. The survey is repeated 30 days later. The most improved schools receive cash prizes. The Project varies by region throughout the State.

West Virginia's effort to encourage motorists to buckle up have paid off. The U.S. Department of Transportation awarded a $5 million grant to the Governor's Highway Safety Program because the state has one of the highest seat belt usage rates in the nation. West Virginia was among five states with a seat belt usage rate of at least 85 percent for two years. The state's usage rate was 88.5 percent in 2006 and 89.5 percent in 2007. The grant was used to buy electronic reporting equipment and to fund driver behavior programs and impaired driving prevention efforts.

Beginning July 10, 2009, because of new legislation passed in the 2009 session, young drivers must follow stronger restrictions on nighttime driving, cell phone use and how many passengers they can carry. Intermediate drivers ages 16 and 17 cannot drive after 10 p.m., not allowed to carry unrelated passengers under age 20 for the first six months and only allowed to carry one for the second six months and not allowed to use cell phones while driving. //2010/

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	352.7	324.2	190.2	257.6	243.1
Numerator	1161	1067	626	848	800
Denominator	329137	329137	329137	329137	329137
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
based upon 2007 Hospital Discharge data, HCA

Notes - 2007
2007 Hospital Discharge data, HCA

Notes - 2006
2006 Hospital Discharge data, HCCRA

Narrative:
/2010/ Injury has been called the neglected disease of modern society. Among persons aged 1-34, unintentional injuries are the leading cause of death in the U.S. and WV. The impact of resulting from violence is also substantial. Annually in the U.S., intentional and unintentional injuries result in over 170,000 deaths, nearly 30 million emergency department visits, and an estimated $406 billion in lifetime medical expenses and lost productivity. Each year, one in five children are needlessly injured, and one in three Americans 65 years and older suffers a serious fall that often results in loss of

independent living or death.

In WV, regional, demographic, and economic factors all continue to produce injury mortality rates that substantially exceed U.S. nationally rates. In addition, people living in rural areas have injury rates that are significantly higher than those residing in urban locations. As the state's land-grant flagship institution for both research and patient care, West Virginia University (WVU) is committed to improving the health and safety of West Virginians, and contributing to the national effort to reduce injuries. While significant improvements in emergency medicine, trauma and injury prevention have occurred over the last 15 years, there remains a critical need for injury research, professional training, and information dissemination activities throughout the state and surrounding region. The WVU Injury Control Research Center is dedicated to addressing this continuing public health problem. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	38.6	44.4	23.4	32.8	30.4
Numerator	127	146	77	108	100
Denominator	329137	329137	329137	329137	329137
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
based upon 2007 Hospital Discharge Data - HCA

Notes - 2007
2007 Hospital Discharge Data - HCA

Notes - 2006
2006 Hospital Discharge Data - HCCRA

Narrative:
/2009/ The percentage of seat belt useage rose to 88.5% in 2006 and to 89.5% in 2007. ***//2010//***

/2010/ The Governor's Highway Safety Program maintains child safety-seat loaner programs throughout the state. These programs not only give away child safety seats, but also check seats for proper installation and provide education to the parents on the need for a properly installed safety seat. This same Program also operates the ATV Safety Program, which seeks to educate the public on ATV Safety and provides an ATV Safety Class throughout the state. //2010//

/2010/ RFTS personnel is also being trained on safe installation of child safety seats. Preventive Health Block resources will be used to purchase car seats for low income families and RFTS will serve as one distribution source. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	67.8	74.8	52.4	76.3	72.6
Numerator	467	515	361	525	500
Denominator	688401	688401	688401	688401	688401
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
based upon 2007 Hospital Discharge Data - HCA

Notes - 2007
2007 Hospital Discharge Data - HCA

Notes - 2006
2006 Hospital Discharge Data - HCCRA

Narrative:
/2010/ Although, the injury rate due to motor vehicles crashes has increased for this population from last year, the injury rate per 100 million vehicle miles of travel overall decreased by 2.4 percent from 2006 to 2007.

Activities targeted at this age group include statewide compliance checks twice yearly: one during prom season and the second during the national DUI mobilization. The Governor's Highway Safety Program, West Virginia State Police, the Alcohol, Beverage, Control Agency(ABCA), and local law enforcement agencies in Cabell and Monongalia Counties are working on a program, which ABCA calls Dream Savers. This is a maximum enforcement effort in these counties, where our two major universities are located, to prevent underage access to alcohol, and requires the cooperative efforts of all participating agencies. The Governor's Highway Safety Program and ABCA are working with every college in the state to address underage drinking on and around each college campus. The colleges have recently formed a state organization to help implement its programs.

The Governor's Highway Safety Program sponsors Students Against Drunk Driving (SADD) Programs throughout the state. WV SADD operating out of the city of Huntington program, maintains the WV Student Leadership Council (SLC). WV SADD has had four students selected for the National SADD SLC and has received national recognition for producing student leaders. (four students on the National SADD SLC from a state the size of WV is unprecedented)

Major enforcement activities include: sobriety checkpoints, saturation patrols, directed patrols, and phantom checkpoints to detect, apprehend, and prosecute all persons who are driving under the influence of alcohol.

Seatbelt programs include the Click It or Ticket Program, which includes seat belt checkpoints, seat belt enforcement, public information and education efforts, and a paid media campaign. //2010//

/2010/ Effective July 10, 2009, young drivers in West Virginia who choose not to enroll in driver education will be required to drive for 50, rather than 30, supervised hours in the learner's phase. Provisional license holders will be prohibited from driving from 10 pm to 5 am instead of the previous 11 pm to 5 am. Additionally, the passenger restriction will strengthen from no more than three passengers to no passengers for the first six months and not more than one passenger for the second six months. //2010//

/2010/ In 2001, WV implemented its graduated driver's license program. Teens can get a learner's permit at age 15, but are subject to supervision and other restrictions. Restrictions are eased at age 16, but only older teens can drive unsupervised between 11 p.m. and 5 a.m. In 2007, WV added a cell phone prohibition to drivers in the learner and intermediate stages. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	14.5	14.3	13.7	15.2	15.1
Numerator	885	872	834	928	920
Denominator	61043	61043	61043	61043	61043
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
based upon 2007 STD Surviallance Summary Report - DSDC

Notes - 2007
2007 STD Surviallance Summary Report - DSDC

Notes - 2006
2006 STD Surviallance Summary Report - DSDC

Narrative:
/2010/ In 2007, West Virginia's chlamydia rate for females was 15.2 per 1,000 compared to the U.S. rate of 30 per 1,000. WV ranks close to the bottom compared to the other states. WV's education policies require that public schools teach some form of sex education, as it relates to HIV/AIDS prevention. Abstinence-based education is primarily stressed and contraception may be covered as part of basic sexual education. However there is no mandate for sexual education. According to the West Virginia Board of Education's Health Content Standards and Objectives for West Virginia Schools (Policy 2520.5), effective November 12, 2005, "a major focus has been given to what the Center for Disease Control recognizes as adolescent risk behaviors," including "sexual behaviors that result in HIV

infection/other STDs and unintended pregnancy." Starting in the seventh grade, students should be able to "analyze the difference between safe and risky behaviors, including methods for preventing pregnancy and STDs (e.g.,abstinence and methods of birth control)."

A state program with a broader approach to sexuality education is the WV Department of Health and Human Resources' Adolescent Pregnancy Prevention Initiative. This program includes abstinence and family planning education and is driven by a group of youth advocates including religious leaders, social workers, teachers and school nurses.

According to the Centers for Disease Control and Prevention, positive indicators regarding high school teens' sexual behavior and contraceptive use across the country are reversing. Presently, more than one-third of teens are sexually active, with less than two-thirds of them reporting using a condom the last time they had sex, indicating a 2% decrease of condom use during the same time period.

These trends that the CDC call "more sex, less contraception" are especially relevant in light of the fact that the teen birth rate has recently increased - the first increase in fifteen years. A survey of West Virginia high school students shows a higher rate of sexual activity than the national average - 53 percent vs. 47 percent. Reported condom use for this group matches the national average at 61% using a condom at last intercourse.

Family planning (FP) continues to offer basic STD counseling, education, screening, diagnosis, and treatment activities. The FP Program, WV Sexually Transmitted Disease Program and WV Office of Laboratory Services jointly administer a pilot project, Urine Based Chlamydia Screening for Women. The pilot project targets women under the age of 25 requesting a urine pregnancy test. Ten FP Program sites were selected to participate based upon clinic volume of urine pregnancy testing. A goal of screening 1,800 women has been set. Once the pilot project and analysis is completed, the findings will be forwarded to each participating agency. Data will be used to determine continued feasibility. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.0	4.6	4.4	5.0	4.9
Numerator	1182	1353	1310	1467	1450
Denominator	294987	294987	294987	294987	294987
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
based upon 2007 STD Surveillance Summary Report - DSDC

Notes - 2007
2007 STD Surveillance Summary Report - DSDC

Notes - 2006
2006 STD Surveillance Summary Report - DSDC

Narrative:
/2010/ Family planning clinics help women plan and space their pregnancies and avoid mistimed, unwanted or unintended pregnancies, reduce the number of abortions, lower rates of sexually transmitted diseases, and significantly improve the health of women, children and families. The WV Department of Health and Human Resources Family Planning Program, housed within OMCFH, despite limited funding, has been ranked sixth nationally in service availability. Services are available confidentially at low or no cost at 153 clinics throughout the state. Any female or male capable of becoming or causing pregnancy whose income is at or below 250% federal poverty level is eligible to receive services. No one is denied services because of inability to pay.

A combination of funds from the U.S. Department of Health and Human Services, Office of Population Affairs, Title V and WV state budget appropriations support most of the services, which include: pregnancy testing; fertility awareness information; free contraceptive methods and supplies; breast, cervical and testicular cancer screenings; and surgical sterilizations for women and men.

Male Screening Expansion Project:
The Family Planning Program continues to collaborate with the WV Sexually Transmitted Disease Program in the Region III Infertility Prevention Male Service Demonstration Project. This project targets high-risk males for urine-based chlamydia screening. Given the problem of re-infection in women and factors involved in not reaching males, a Male Demonstration Project has been on-going from 2002-2008 in juvenile detention centers, school based health centers, and selected Special Agreement sites. The APTIMA Combo II Assay (the urine NAAT test for chlamydia) has been used to determine the positivity rate for asymptomatic men. The semi-automated protocol has been used in these tests instead of the fully automated system due to limited funding. From 2002 - September 2008, 25,902 males have been screened through the urine screening project, surpassing the original goal of 300 males. Of the 1,912 males tested in the project during 2007, 572 were positive for chlamydia and 566 for gonorrhea. The Office of Laboratory Services updated testing procedures with the PACE 2 APTIMA system in October 2008. Chlamydia and gonorrhea screening for all clients (female or male) is now conducted with urine specimens.

The majority of males served through the urine based chlamydia screening project are residents of correctional facilities, detention centers and juvenile centers. Medical services for these males are provided through the Office of Military Affairs federal contract. Starting July 1, 2008 all males served through the urine based chlamydia screening project received a Family Planning Program brochure explaining where they can receive treatment after serving their sentence. Coordination with the HIV/AIDS/STD Program is ongoing to collect data. See HSI 05A for additional information. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	20443	18892	911	39	160	9	432	0
Children 1	84009	77353	3967	125	671	16	1877	0

through 4								
Children 5 through 9	104779	96106	5408	201	756	28	2280	0
Children 10 through 14	107578	99695	4982	206	742	33	1920	0
Children 15 through 19	117478	109538	5440	273	688	36	1503	0
Children 20 through 24	112294	104028	5333	336	1380	54	1163	0
Children 0 through 24	546581	505612	26041	1180	4397	176	9175	0

Notes - 2010

Narrative:
/2010/ West Virginia is characterized by an aging population and is predominantly white. The largest minority group is African American, with a growing Latino population, especially in the eastern panhandle, located close to Washington, D.C. Of West Virginia's 1.8 million people, 546,581 are ages 0-24. The majority are white, with 40,969 or 7.5% being of another or mixed race. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	20204	239	0
Children 1 through 4	82792	1217	0
Children 5 through 9	102956	1823	0
Children 10 through 14	105833	1745	0
Children 15 through 19	115937	1541	0
Children 20 through 24	110624	1670	0
Children 0 through 24	538346	8235	0

Notes - 2010

Narrative:
/2010/ West Virginia is characterized by an aging population and is predominantly white. The largest minority group is African American, with a growing Latino population, especially in the eastern panhandle, located close to Washington, D.C. Of West Virginia's 1.8 million people, 546,581 are ages 0-24. The majority are white, with 40,969 or 7.5% being of another or mixed race. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	31	24	4	0	0	0	3	0
Women 15 through 17	729	680	41	2	0	0	6	0
Women 18 through 19	1977	1878	87	2	0	1	9	0
Women 20 through 34	17262	16491	580	15	71	70	35	0
Women 35 or older	2018	1912	59	5	19	20	3	0
Women of all ages	22017	20985	771	24	90	91	56	0

Notes - 2010

Narrative:
/2010/ In 2007 of the 22,017 births, 20,985 or 95.3% were to white women, 771 or 3.5% were to Black women and 2.2% were to others.

Statistics show an increased incidence of poor perinatal outcomes among minority women, and certain perinatal risk factors appear to be more prevalent among this population. Prenatal care is important in evaluating risk, promoting health, and managing complications in pregnancy, yet disparity of and access to care place these vulnerable women at increased risk. The Perinatal Partnership will study these disparities and work to find a solution that works for West Virginia.

Teen pregnancy in West Virginia is disproportionately higher among the State's African American population with 103 pregnancies per 1,000 African American teens vs 66 pregnancies per 1,000 white teens. Of the 771 Black births 132 or 17% were to women ages 14-19. Of the 20,985 white births, 2,737 or 13% were to women ages 14-19.

Family planning clinics help women plan and space their pregnancies and avoid mistimed, unwanted or unintended pregnancies, reduce the number of abortions, lower rates of sexually transmitted diseases, and significantly improve the health of women, children and families. In 2007, 748 male teens and 15,060 female teens were served in one of the Family Planning clinics around the state.

Nearly half of pregnancies among American women are unintended, and four in 10 of these are terminated by abortion according to the Perspectives on Sexual and Reproductive Health, 2005, 38(2);90-96. The West Virginia Health Statistics Center collects information on all abortions performed in the state as does Alan Guttmacher Institute. However, this data is problematic since it does not account for women traveling out of state to procure services. The WV Health Statistics Center reports that after years of a decline in the abortion rate there was an increase in 2006. In 2007, there were 1,849 induced terminations of pregnancies (ITOPs) performed in West Virginia, 9.2% less than in 2006 (2,037). Nearly nine out of every ten (89.7%) 2007 ITOPs involved a West Virginia resident, while 5.8% were Ohio residents and 3.7% were residents of Kentucky, compared with 2006 percentages of 89.7%, 5.4%, and 3.8%, respectively. The median age of women having an ITOP in 2007 was 23, same as in 2006. There were 122 procedures in 2007 involving females under the age of 18, of which 119 were to unemancipated minors compared with 108 in 2006, of which 100 were unemancipated minors.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	31	0	0
Women 15 through 17	715	14	0
Women 18 through 19	1953	24	0
Women 20 through 34	17045	217	0
Women 35 or older	1989	29	0
Women of all ages	21733	284	0

Notes - 2010

Narrative:
/2010/ Of the 22,017 live births to WV residents in 2007, only 284 were born to mothers of Latino or Hispanic origin. Of those 284 Latino or Hispanic births, 38 or 13.4% were born to Latino teens ages 15-19. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	163	145	17	0	0	1	0	0
Children 1 through 4	31	28	3	0	0	0	0	0
Children 5 through 9	22	22	0	0	0	0	0	0
Children 10 through 14	18	16	2	0	0	0	0	0
Children 15 through 19	82	79	3	0	0	0	0	0
Children 20 through 24	156	146	9	0	0	0	1	0
Children 0 through 24	472	436	34	0	0	1	1	0

Notes - 2010

Narrative:
/2010/ West Virginia is primarily a homogenous society, with less than 4% Black. Of the 472 death for the above age group 34 or 7% were Black. Of the 34 Black deaths, ages 0-24, 17 or 50% were infants. The Black infant deaths were characterized by extreme prematurity, born before 27 weeks gestation, unmarried parents, young parents age 21 years or younger and poor adequacy of prenatal visits. Of the 472 White deaths, ages 0-24, 28 or 33% were infants.

The state's 2007 white infant mortality rate increased slightly, from 6.8 in 2006 to 6.9, while the rate for black infants decreased from 29.2 to 22.0 //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	163	0	0
Children 1 through 4	30	1	0
Children 5 through 9	22	0	0
Children 10 through 14	18	0	0
Children 15 through 19	82	0	0
Children 20 through 24	152	4	0
Children 0 through 24	467	5	0

Notes - 2010

Narrative:
/2010/ There were 472 deaths within the population of 0-24 years of age. Deaths of infants and children ages 20-24 were the two largest age groups and combined was 67.5% of deaths for children ages 0-24. Of the 472 deaths, five deaths were reportedly of Hispanic/Latino origin. Four of the five were to children 20-24 years of age. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	434287	401584	20708	844	3017	122	8012	0	2007
Percent in household headed by single parent	13.3	12.6	35.8	14.8	5.3	20.5	18.4	24.6	2008
Percent in TANF	3.6	3.6	0.0	0.0	0.0	0.0	0.0	0.0	2008

(Grant) families									
Number enrolled in Medicaid	206729	206729	0	0	0	0	0	0	2008
Number enrolled in SCHIP	37707	35759	1427	18	88	7	387	21	2008
Number living in foster home care	6636	5404	735	13	16	23	431	14	2008
Number enrolled in food stamp program	101087	101087	0	0	0	0	0	0	2008
Number enrolled in WIC	46234	41244	1848	133	91	16	2902	0	2008
Rate (per 100,000) of juvenile crime arrests	2346.0	2098.0	7743.0	835.0	734.0	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	4.4	4.4	4.9	9.8	1.5	0.0	0.0	0.0	2007

Notes - 2010
2000 Census - male, female head of household with children under 18 divided by total family households

not broken down by race

Fiscal Year 2008
includes children to age 20
not broken down by race

2008 Annual Report
only includes children 18 and under

not broken down by race

denominator = total children ages 10-19
Asian and Pacific Islander calculated as one under Asian (report from Juvenille Justice)
Total Unknown arrests was 69 - not calculated as rate because Unknown total from Vital was 0

2007-2008 school year

AFCARS report October 1, 2008 - March 31, 2009

Narrative:
/2010/ A few of the categories listed above are not broken down by race and indicated in the note sections of each of these data fields. Fifty-six percent of West Virginia's children ages 0-19 have been enrolled in either Medicaid or SCHIP in 2008. Of importance to note in the above data is the rate of Black juvenile crime arrests compared to the White juvenile

crime arrests and that 35.8% of Black children live in households headed by a single parent. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	427722	6565	0	2007
Percent in household headed by single parent	13.2	0.1	0.0	2008
Percent in TANF (Grant) families	3.6	0.0	0.0	2008
Number enrolled in Medicaid	0	0	206729	2008
Number enrolled in SCHIP	0	0	37707	2008
Number living in foster home care	98	5450	237	2008
Number enrolled in food stamp program	101087	0	0	2008
Number enrolled in WIC	44998	1236	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2346.0	2007
Percentage of high school drop-outs (grade 9 through 12)	4.4	3.5	0.0	2007

Notes - 2010
2000 Census - male or female head of household with children under 18 divided by total other family households

not broken down by ethnicity

Fiscal Year 2008
includes children to age 20
not broken down by ethnicity

2008 Annual Report
only includes children 18 and under
not broken down by ethnicity

not broken down by ethnicity

Ethnicity not reported by Juvenille Justice - calculated rate based on all arrests

2007-2008 school year

AFCARS report October 1, 2008 - March 31, 2009

Narrative:
/2010/ Only 1.5% of the children living in WV are reported as Latino. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	86857
Living in urban areas	199772
Living in rural areas	234515
Living in frontier areas	0
Total - all children 0 through 19	434287

Notes - 2010
based upon 2% of total age group population

based upon 46% of total age group population

based upon 54% of total age group population

no designated frontier areas in West Virginia

Narrative:
/2010/ The second most rural state in the nation, 20 of West Virginia's 55 counties are 100% rural according to the Census Bureau definition, with an additional 14 designated as 75% rural. Geographically, the region is characterized as having a rolling topography with rugged ridges and hilltops reaching upwards of 4,000 feet with remote valleys in between. The valleys often feel isolated and separated from the urbanized areas. It is this isolated feeling, ingrained in the landscape that has contributed to the strong sense of independence and family among Applalachians. For as much beauty as the geography brings, it can also be treacherous and impassable, causing a major barrier in accessing healthcare.

Culturally, Appalachians have core values and beliefs such as individualism and self-reliance. These same core values, which breed strong ties to family and tradition, also reflect detrimental health behaviors, the effects of conservative religion on medical care use, and feelings of alienation from national society.

Primary Care Centers are health care organizations, founded and operated by rural communities in West Virginia. They are funded, in part, by State and Federal grants administered by the Division of Primary Care. These grants help the clinics offer more services and better healthcare for their patients, regardless of the patient's ability to pay. Currently, in WV, there are 34 primary care organizations. Most, but not all, provide more than one clinical site. These primary care centers also house 17 Black Lung clinic sites and operate 36 School-Based Health Centers. This system of healthcare is constantly endeavoring to grow in accessibility and variety of services provided to engage West Virginian's in healthcare. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1801921.0
Percent Below: 50% of poverty	19.0

100% of poverty	21.0
200% of poverty	60.0

Notes - 2010
State Health Fact by Kaiser Foundation

West Virginia: Distribution of Total Population by Federal Poverty Level(2006-2007)

West Virginia: Distribution of Total Population by Federal Poverty Level(2006-2007)

West Virginia: Distribution of Total Population by Federal Poverty Level(2006-2007)

Narrative:
/2010/ Because of the loss of higher paying jobs over the past thirty years in West Virginia, there has been a concurrent rise in the state's poverty rate. West Virginia's unemployment rate climbed to 7.8 percent in April 2009 up from 5.1% from May 2008. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	434287.0
Percent Below: 50% of poverty	15.0
100% of poverty	20.0
200% of poverty	65.0

Notes - 2010
based upon West Virginia: Distribution of Total Population by Federal Poverty Level(2006-2007)
Kaiser Foundation
State Health Facts

based upon West Virginia: Distribution of Total Population by Federal Poverty Level(2006-2007)
Kaiser Foundation
State Health Facts

based upon West Virginia: Distribution of Total Population by Federal Poverty Level(2006-2007)
Kaiser Foundation
State Health Facts

Narrative:
/2010/ Sixty-five percent of WV's residents ages 0-19 are living at 200% below the Federal Povery Level. Even so, because of the State's efforts to increase eligibility for CHIP up to 300 percent of the FPL by 2010, almost all children are insured in WV. The high rate of poverty does not seem to affect parents positive perceptions of their child's medical status. According to the 2007 National Survey of Children's Health, West Virginians responded positively stating that 86.8% believed their children were in exellent or very good health, 75.4 believed their child had excellent or very good oral health. Parents stated 94.1 percent of the children had health insurance, 91.4% received a preventive medical visit in the past year, 80.3% had a preventive dental visit in the past year, 57.1

percent had families who read to them everyday and 66.1 percent lived in families who sang or told them stories everyday. Eight-seven point six (87.6) percent believe they live in a supportive neighborhood and 92.3% stated that they live in neighborhoods that are usually or always safe. The above comments were rated as higher than the national average. Survey questions that rated below the national average included: percentage of children who live in neighborhoods with poorly kept or dilapidated housing - 24.3%; percentage of children who live in households where someone smokes - 38.2%; percent of children age 6-17 who missed 11 or more days of school in the past year - 8%; and percent of children age 0-5 with injuries requiring medical attention in the past year - 13.9%. //2010//

F. Other Program Activities

The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCFH agreement. The exception to this format is Children Special Health Care Needs, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its direct service responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. The program receives referrals from multiple sources. However, as the State has developed and improved population-based surveillance systems, more and more youngsters have been referred, as a result of the birth defect registry, birth score, blood lead testing, newborn hearing screening and metabolic screening. It is also important to note that the State's universal risk scoring of infants, called Birth Score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the OMCFH administered Birth to Three Program/Part C IDEA. In addition, MCFH administers EPSDT, for children not enrolled in an HMO, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff who serve as technical resources to the medical community.

All children assessed by CSHCN receive evaluation and case management services to facilitate access to additional services. All children enrolled in CSHCN, Birth to Three (Part C IDEA), or even our perinatal RFTS program receive case management and care coordination. Children participating in the Children with Special Health Care Needs Program access Medicaid, at a rate of 85.9%. This high percentage is attributed to CSHCN commitment to assist families with SSI applications, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group.

The Office supports the Birth Score Project and Genetics Program administered by West Virginia University, Department of Pediatrics. The support for these programs are at the heart of building capacity for the system of care by providing preconceptual counseling; assessment and support for persons with congenital anomalies' and operating a population-wide surveillance system designed to identify infants at possible risk of post-neonatal death (birth score, which includes newborn hearing screening).

Primary preventive health care for the State's children has been historically administered by OMCFH through provider contracts for EPSDT. Because Medicaid mandated enrollment of clients into HMOs, the WV EPSDT Program called HealthCheck is serving fewer and fewer clients.

The OMCFH continues to provide monies for maintenance of a data repository which keeps current health, social, and community information by county and by type of service statewide. This data repository, linked to OMCFH via modem, is used to access information for client specific questions, received on the OMCFH toll-free lines. As previously discussed, OMCFH has well used toll-free lines which are monitored by independent reviewers. All calls, unless client refuses, are followed up by letter. We also maintain resource information on a variety of topics enabling us to respond to specific concerns. OMCFH program information is also available via Web access with multiple links to access informational guidance on a variety of topics.

Care management and care coordination is provided through established systems, with program specific protocols for each targeted population. In RFTS, social workers and registered nurses involve parents in discussion of family planning, and assist clients who are economically disadvantaged in accessing health care. Our cadre of community-based family outreach workers (FOW's) encourage families to participate in preventive, primary health care for their children through EPSDT.

Cervical cancer is one of the leading causes of cancer-related death among West Virginia women aged 25-44 years. The 2004 age-adjusted invasive cervical cancer incidence rate is 9.6 per 100,000. The opportunity to provide cervical cancer screening through the WVBCCSP is part of our effort to improve the quality of life for West Virginians. Women who meet certain clinical guidelines may also be eligible to receive a human papillomavirus (HPV) test through the WVBCCSP. This data is monitored through the WVBCCSP's surveillance system. Women diagnosed with invasive cervical cancer can also receive case management services and a Medicaid card through a partnership with the Office of Maternal, Child, and Family Health and the West Virginia Bureau for Medical Services if they are medically indigent.

/2009/
•Federal guidelines mandate that all NBCCEDP grantees have a never or rarely screened rate of > than or equal to 20%. Never or rarely screened is defined as a woman who has never had a Pap test or has had one, but it was five or more years ago. The WVBCCSP has increased the percentage of serving never or rarely screened women from 4.5% in 2002 to 41.4% in 2007.
•In October 2006, the WVBCCSP published, "Assessing Awareness and Knowledge of Breast and Cervical Cancer Among Appalachian Women" in the peer-reviewed CDC e-journal Preventing Chronic Disease.
•The WVBCCSP is increasing the number of women aged 50-64 receiving mammograms through the Program. The proportion of mammograms provided to women 50-64 years of age has increased from 64.9% in 2002 to 86.8% in 2007.
•Over the past several years, the WVBCCSP has participated in several studies including: the CDC's MDE Validation Project and NBCCEDP Cost Effectiveness Study; the federal Government Accountability Office's Access to Mammography Study, and George Washington University's Breast and Cervical Cancer Prevention and Treatment Act Study.
•During October 2007, 75 activities were conducted by the WVBCCSP as part of Breast Cancer Awareness Month.
•Nineteen Walks for Women were conducted in 2007 to raise awareness about breast cancer.
•During FY 2006-2007, 50 free screening clinics were conducted. A total of 1,032 women were screened and 640 were enrolled.
•A new vendor was awarded the cytology contract for the WVBCCSP and Family Planning Program effective November 1, 2006. The new vendor is Cytology Services of Maryland (CSM).
•The WVBCCSP transitioned from conventional Pap testing to liquid-based Pap testing during FY 2007-2008. //2009//

Hearing is important to child development. Early identification of hearing defects is addressed three ways in West Virginia:

1.The newborn hearing screening efforts that occur at time of birth, see early references elsewhere in grant submission;

2.EPSDT screenings of all children eligible for Medicaid; and
3.Universal screening across all payors using the EPSDT protocol, for children entering kindergarten (ages 3, 4, 5 and 6).

Infants identified with hearing loss are tracked and if hearing amplification and treatment is required, CSHCN Program works with the child's insurance to secure treatment including hearing aids. Because child development can be severely impaired young infants/toddlers and family are offered a referral to Ski*Hi which is a free comprehensive home-based pre-school/parent education program for deaf and hard of hearing children ages birth to five years and their families. The goal of Ski*Hi is to use the child's natural environment to improve and increase the child's language and communication skills. Referrals to Ski*Hi can be made electronically by accessing: http://wvsdb2.state.k12.wv.us.

To prevent duplication Ski*Hi and West Virginia Birth to Three (Part C/IDEA) collaborate to develop intensive educational and developmental programs for children birth through age 2. Because Ski*Hi eligibility goes beyond age 2, they can serve all those who age out of BTT.

Ski*Hi parent advisors work with the parents of children who are deaf or hard of hearing to connect families to resources, including the WV Association for the Deaf. The Association offers members and non-members opportunity for socialization as well as problem solving discussions. To make the Association more accessible Town Hall Meetings are scheduled throughout WV.

G. Technical Assistance

/2010/ West Virginia has strong Program components within the State's perinatal Program, Right From the Start, however one of the weaknesses identified is a low percentage of Medicaid eligible and high risk pregnant women being served by this strictly volunteer Program. RFTS personnel have identified the need to receive education and training on how to interview and engage clients to particpate and receive services. This is an important aspect as all Medicaid recipients are eligible, yet only approximately 25% receive any RFTS service. This population group has the highest rate of smoking while pregnant, SUID incidences, premature infant deaths, etc. //2010//

V. Budget Narrative

A. Expenditures

Please reference notes contained with forms 3, 4 and 5 for a dicussion of budgeted estimates and actual expenditures.

B. Budget

The Office of Maternal, Child and Family Health has done a good job of leveraging resources. The Block Grant Title V, serves as the foundation but the Office also administers Title X Family Planning; Title XV Breast and Cervical Cancer Screening Program; Part C/IDEA; Childhood Lead Prevention Program, CDC funded; EPSDT, funded by Title XIX; Children with Special Health Care Needs, funded by Title XIX and Title V; and PRAMS, funded by CDC. All of these funding streams augment what is purchased with Title V monies. Like many states across the country, Title V has moved away from the sole focus of purchasing or providing individual health services and has placed most of our attention and fiscal resources on developing a system of care. For example, because the state had high incidences of neural tube defect and other congenital anomalies, the OMCFH approached the WVU School of Medicine to develop satellite clinics providing genetics counseling and screening. Although the medical expertise came from the WVU School of Medicine, the funding to make these services more accessible throughout the state came from Title V. These clinics serve everyone, not just persons who have government sponsored health care.

Because WV has a median income of $27,000 for a family of four, the need for services has been great but our resources have been limited. The State Legislature routinely supports Maternal, Child and Family Health, but over the years this commitment has not kept pace with the demand for services and escalating cost. This is largely attributable to the fact that as Medicaid expansions occurred and the CHIP program was introduced, there was an assumption by members of the State Legislature that Maternal, Child and Family Health would not need as many resources. We have attempted to educate the Legislature explaining to them that while these alternate health financing strategies have come into being, the MCH monies are needed to improve the quality of services rendered and improve the availability of care. Like states across the country, WV does not have enough money to fund all the many things that we would like to have for our citizens. For example, several years ago newborn hearing screening legislation was passed but there was no accompanying state appropriation. What was obvious to us was that, while there was a commitment to identify children who needed intervention, be it hearing aids or whatever, there was no consideration given to the fact that there has to be a mechanism for identifying the children, tracking the children, and making sure the intervention occurred, all of which costs money. OMCFH staff argued this to no avail, so we were very pleased to be a recipient of the Title V monies to support this project. It is true that Medicaid and some insurers would offset the cost of the newborn hearing screening services, but there was no way to individually bill and recover monies necessary for the population-based tracking and surveillance that was necessary...no insurances or Medicaid pay for this activity.

In order to be good stewards of the system, the OMCFH provides leadership for much of the health care services provided in the state. Medicaid, CHIP and others are purchasers, but the OMCFH and its staff recruit the clinicians, establish the care protocols, monitor provider behavior, offer skill building opportunities, etc., all using the resources identified above to improve WV's health care system.

/2010/ The WV OMCFH administers EPSDT on behalf of Medicaid, for children not enrolled in an HMO, and has done so for approximately 30 years. The Medicaid Bureau supports the program by paying for individual health services that the children access and administrative support for salaries of the MCFH team administering EPSDT. //2010// The OMCFH develops, distributes, and purchases anticipatory guidance which is used by the

participating providers. We also are responsible for bringing together members of the medical community to provide guidance as it relates to child health, not just EPSDT, but Newborn Hearing, Children with Special Health Care Needs, Birth Defects, Lead, etc. We use many of the programs cited to identify children who are ultimately referrred to CSHCN. The CSHCN Program, financed under Medicaid and Title V, not only serves children who have diagnosed chronic and debilitating conditions but arranges assessment for children referred by their primary care/medical home. All of these efforts are our commitment to primary and preventive care of the state's children and ultimately have a tie-in to CSHCN when indicated.

Using the statutory authority under Title V that allowed for cost based reimbursement for Medicaid beneficiaries and the authority invested in Title V to be responsible for all populations, we embarked upon an ambitous redesign plan for our Birth to Three/Part C system. This redesign has allowed the State of WV to implement a system change that is more in keeping with tenents of Part C and to obtain financing necessary to support the system. This system is designed to serve children who are developmentally delayed or at risk of developmental delay, but the many programs administered by the Office serves as a referral conduit. Referral sources include the Birth Score screening that is completed on every baby born in WV to screen for developmental delay or identify those at risk of post neonatal death, our Birth Defects Surveillance System, Metabolic and Newborn Hearing Screening programs, and of course EPSDT. This system change has been in the process for about four years and has resulted in families having an opportunity to select a provider of service, improved financing for the system, and assurance that families are served by appropriately credentialed personnel. We have used Title V connections and fiscal resources to secure support from the medical community including developing physician training programs, offering skill building around the early detection of developmental delay, and to champion messages to their colleagues that the early identification of children who are at risk are important to us all.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.